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Insurance Law

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INSURANCE LAW

*J. Price Collins**
*Lara K. Forde***

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I. CARRIER'S RIGHT OF REIMBURSEMENT

TEXAS *Association of Counties v. Matagorda County: Texas Supreme Court Denies Insurer Right to Reimbursement for Settling Uncovered Claims Under Reservation of Rights*

Probably the most anticipated insurance-related opinion during the Survey period was the Texas Supreme Court's decision in *Texas Association of Counties County Government Risk Management Pool v. Matagorda County*.¹ In that case, the Texas Supreme Court held that a liability insurer was not entitled to reimbursement from its insured for the amount paid by the insurer, under a reservation of rights, to settle an excluded claim. The underlying litigation arose in 1993, when inmates assaulted three other prisoners (the "Coseboon plaintiffs"). The Coseboon plaintiffs sued the insured, Matagorda County and its sheriff, both of whom demanded that the Texas Association of Counties County Government Risk Management Pool ("TAC") defend and indemnify them under a law enforcement liability insurance policy. TAC initially denied coverage because of the jail exclusion; however, after negotiations with the insured, TAC agreed to pay the defense costs incurred by the insured's counsel, subject to a reservation of rights to continue to deny coverage.² TAC also filed a declaratory judgment action seeking a declaration that the claims were not covered.³

The Coseboon plaintiffs eventually offered to settle their lawsuit for \$300,000, which was within the policy limits. The insured demanded that TAC settle the claim, and TAC stated that it would settle subject to a reservation of rights and that it would seek reimbursement from the insured. The insured did not object to the settlement and stipulated that it did not dispute the reasonableness of TAC's settlement of the litigation. After the settlement, TAC amended its declaratory judgment action. In the amended petition, TAC sought reimbursement of the settlement funds. The trial court entered judgment for TAC on the coverage issues, and it awarded TAC \$300,000 for its settlement payment, together with interest, attorneys' fees, and costs. The insured appealed. "The court of appeals concluded that no equitable remedy allowed TAC to recover the settlement funds and that there was no indication that the County agreed either to be bound by the settlement or to reimburse TAC."⁴ The court of appeals reversed and rendered judgment that TAC take nothing. TAC appealed to the Texas Supreme Court.⁵

As a matter of first impression, the court considered whether an insurer may seek reimbursement of settlement funds from its insured, paid

1. *Tex. Ass'n of Counties County Gov't Risk Mgmt. Pool v. Matagorda County*, 52 S.W.3d 128 (Tex. 2000).

2. *Id.* at 129.

3. *Id.* at 129.

4. *Id.* at 130-31.

5. *Id.* at 131.

under a reservation of rights, upon an adjudication of noncoverage. TAC argued that a right of reimbursement was consistent with the express allocation of risk agreed to and accepted by the insured in the coverage document. TAC pointed out that claims not covered under the policy remained the responsibility of the insured; therefore, the insured should be required to contribute its full share of liability for reasonable amounts paid to settle contractually excluded claims. The Texas Supreme Court rejected this argument, holding that a right of reimbursement was not supported by any express agreement between TAC and the insured.⁶ The court suggested that an insurer is not entitled to reimbursement from its insured for payment of non-covered claims, unless the insurance contract expressly provides for reimbursement or the parties otherwise agree to such a right. The Court further suggested that when TAC notified the insured that TAC would fund the settlement subject to a reservation of rights and that it would seek reimbursement from the insured, TAC unilaterally attempted to create additional rights not contained in the coverage document. Therefore, TAC's reservation letter was ineffective.⁷

TAC also maintained that a right to reimbursement is consistent with Texas public policy, because it encourages settlement, reduces litigation, and eliminates uncertainty by capping the insured's liability for third-party claims. Specifically, TAC explained that if an insurer is not permitted to take advantage of a reasonable settlement opportunity prior to resolution of the coverage dispute, then the insured faces potentially greater liability to the third-party claimant and increased costs associated with defending the underlying lawsuit. This is in addition to the costs of defending the declaratory judgment action and a possible attorneys' fee award in favor of the insurer under the Declaratory Judgment Act. On the other hand, if an insurer can obtain a favorable settlement of the underlying claim without fear of waiving its coverage defenses, costs of defending the underlying claim can be significantly reduced, or even eliminated in some cases, and the insured's liability will be capped at a reasonable, liquidated amount. The Texas Supreme Court appeared to recognize that denying reimbursement places insurers in an untenable position. However, the court held that the "insurers are better positioned to handle this risk, either by drafting policies to specifically provide for reimbursement or by accounting for the possibility that they may occasionally pay uncovered claims in their rate structure."⁸

TAC further argued that the insured was unjustly enriched as a result of TAC's payment of the non-covered claim and that reimbursement was consistent with the equitable principles of *quantum meruit* and unjust enrichment. TAC contended that the equities in the case weighed in favor of allowing a right of reimbursement.⁹ Thus, TAC argued that an obliga-

6. *Matagorda County*, 52 S.W.3d at 131.

7. *Id.* at 131-32.

8. *See id.* at 135.

9. Specifically, TAC pointed out that: (1) it dealt with the insured fairly and in good faith, (2) it provided a defense under a reservation of rights rather than standing rigidly by

tion of reimbursement should be imposed to prevent the insured from being unjustly enriched. Despite the clear windfall to the insured, the Texas Supreme Court refused to recognize a quasi-contractual right of reimbursement. The court explained that the insured's clear and unequivocal consent to settlement and agreement to permit the insurer to seek reimbursement is required, "[o]therwise, the insured is forced to choose between rejecting a settlement within policy limits or accepting a possible financial obligation to pay an amount that may be beyond its means at a time when the insured is most vulnerable."¹⁰ Thus, the Texas Supreme Court affirmed the court of appeals' holding that TAC was not entitled to recover the cost of settling the uncovered claim.

Justice Owen and Justice Hecht argued in the dissent that an obligation of reimbursement should be imposed to prevent the insured from being unjustly enriched. Specifically, the dissent stated:

An obligation of reimbursement should be imposed when an insurer pays an amount that the insured agrees is reasonable to settle a claim that is not covered. This rule of law would preserve the respective rights and obligations of parties to an insurance contract. An insured would be responsible for liabilities it incurs that are not covered by the policy of insurance. In this case, there is no principled basis for requiring [TAC] rather than Matagorda County to bear the cost of settling the Coseboon litigation. There is no dispute that the amount the [insurer] paid to settle the matter was reasonable. Matagorda County is receiving a benefit for which it did not bargain—payment of a claim that was not covered under its agreement with [TAC]. Matagorda County has been unjustly enriched because it paid nothing to settle a serious claim against it. [TAC] has paid an obligation that was Matagorda County's alone.¹¹

Although the Texas Supreme Court's decision did not address defense costs, Justice Hecht observed in the dissent that the holding would preclude a right of reimbursement for defense costs. Specifically, Justice Hecht raised concerns about the court's statement that "a unilateral reservation-of-rights letter cannot create rights not contained in the insur-

its original denial, (3) when the opportunity arose to settle the *Coseboon* claim for a reasonable amount, TAC funded the settlement despite the coverage dispute, benefiting the insured by capping its liability at a reasonable amount, (4) TAC did not force the settlement on the insured, but rather obtained the exact result the insured wanted, and (5) the insured was put on notice that TAC expected to be reimbursed for the settlement if it was later determined that the claim was not covered.

10. 52 S.W.3d at 134. In reference to this argument, the dissent observes:

A reasonable settlement offer is one that the insured, acting as a person of ordinary care and prudence, would accept. In situations like the one before us, when there was a coverage dispute, an insured's knowledge that it ultimately may have to fund a settlement offer will cause the insured to make a fair evaluation of whether the settlement offer is in fact a reasonable one. But regardless of the size of the claim that is not covered, the financial obligation to pay the claim remains with the insured. An insured's lack of financial resources does not change that fact.

Id. at 138.

11. *Id.*

ance policy.”¹² The dissent points out that this statement is “not only overly broad, but is a misstatement.”¹³ For example, the dissent explains that an insurer “can bind itself in a reservation-of-rights letter to pay defense costs,” even if the claims are not covered, by reserving its rights only as to indemnity.¹⁴ The dissent explained that under Texas law, where an insurance company tenders a defense subject to a reservation of rights, the insured may either accept the tendered defense or it may refuse the tendered defense and defend itself.¹⁵ If the insured defends itself, then the insured must pay the defense costs if the claims are excluded by the applicable policy. The dissent opines that the insured should be responsible for the cost incurred in defending excluded claims regardless of whether it accepts the tendered defense or defends itself.¹⁶ Thus, the dissent warns insurers that this decision may foreshadow how the Court will address this issue if it is presented.¹⁷

II. EXTRACONTRACTUAL LIABILITY

In 2001, Texas courts continued the trend of making it more difficult for a plaintiff to recover on extra-contractual claims. The appellate courts confirmed that an insured must first establish that an insurer breached its contractual duty as a prerequisite to recover on an extra-contractual claim. Several courts’ decisions reinforced the rule that an insurer does not commit bad faith merely because it makes an incorrect coverage determination. The courts clarified that insurers are not liable for the tort of bad faith for denying questionable claims so long as the insurer had a reasonable basis to deny or delay payment even if the basis is eventually determined by the fact finder to be erroneous. Thus, insureds must overcome a difficult burden in order to prevail on extra-contractual claims.

A. DUTY OF GOOD FAITH AND FAIR DEALING

1. *No Liability Absent Proof of Breach of Contract*

Gates v. State Farm: Insured’s Failure to Establish Breach of Contract Negated Essential Element of Bad Faith Claim

In *Gates v. State Farm County Mutual Insurance Co. of Texas*,¹⁸ the Dallas Court of Appeals addressed whether a final judgment in favor of

12. *Id.* at 140.

13. *Id.*

14. *Matagorda County*, 52 S.W.3d at 140-41.

15. *Id.* at 140-41.

16. *Id.*

17. The court of appeals recognized a right to reimbursement of defense costs. Other jurisdictions have also recognized a right to reimbursement for defense costs of excluded claims. Thus, the denial of such defense costs appears to be inconsistent with the trend in other jurisdictions. See *Buss v. Superior Court of Los Angeles County*, 939 P.2d 766 (1997).

18. 53 S.W.3d 826 (Tex. App.—Dallas 2001, no pet.).

an insurer on a breach of contract claim precludes an insured's bad faith claim as a matter of law. This case arose after the insureds filed a claim with their insurer, State Farm, as a result of an automobile accident with an uninsured motorist. After they were unable to reach a settlement with State Farm, the insureds filed suit against State Farm asserting claims for breach of contract and bad faith. The court severed the contractual claim from the bad faith claims and abated the bad faith claims until the contractual claims were resolved. In the contract action, the trial court granted summary judgment in favor of State Farm. The insureds did not appeal that judgment, and it became final.

In the bad faith action, the insureds alleged that State Farm breached its common-law duty of good faith and fair dealing by (1) refusing to pay their claim without a reasonable basis to do so, (2) making substantially inadequate settlement offers, and (3) failing to properly investigate the claim.¹⁹ The insureds sought to recover the policy limit of their uninsured/underinsured motorist coverage, as well as damages for mental anguish. After the judgment in the contract claim became final, State Farm moved for summary judgment on the bad faith claim in part on the ground that the insureds' failure to prevail on the contract claim precluded any recovery based on bad faith denial of the claim. Without explanation, the trial court granted State Farm's motion for summary judgment.²⁰

On appeal, the insureds argued that their bad faith claim was not automatically precluded simply because their contract claim was dismissed on summary judgment. Specifically, the insureds asserted that there was some evidence of coverage and that they lost their breach of contract suit only because they failed to prove damages and causation. Thus, the insureds argued that because contract and tort claims are separate and because they presented some evidence of coverage, the final judgment on their breach of contract claims should not preclude their bad faith claims. The court of appeals rejected this argument, stating that "in most circumstances, an insured may not prevail on a bad faith claim without first showing that the insurer breached the contract."²¹ The court held that the summary judgment evidence conclusively established the existence of a reasonable basis to deny the insured's claim (i.e., that the claim was not covered), thereby negating an essential element of the insureds' common-law bad faith claims. Moreover, the court noted that "to allow the [insureds] to present evidence of a contract breach in a later lawsuit after an adverse determination on the merits would be an impermissible collateral attack on the final judgment in the contract case."²² Accordingly, the court held that State Farm's final judgment on the insureds' breach of contract claims precluded, as a matter of law, recovery on the insureds'

19. *Id.* at 828.

20. *Id.*

21. *Id.* at 830 (quoting *Liberty Nat'l Fire Ins. Co. v. Akin*, 927 S.W.2d 627, 629 (Tex. 1996)).

22. *Id.* at 830.

bad faith claims stemming from the same accident.²³

Laas v. State Farm: No Bad Faith Where Insurer is Found Liable for an Amount Less Than the Amount It Offered to Settle a Disputed Claim

The Houston Court of Appeals reached a similar conclusion in *Laas v. State Farm Mutual Auto Ins. Co.*²⁴ In that case, the insureds obtained property damage and personal injury policy limits from the insurer of the driver of the other vehicle following an automobile accident. The insureds then sued their insurer, State Farm, to recover underinsured motorist benefits. The insureds alleged that State Farm breached its duty of good faith and fair dealing and violated Article 21 of the Insurance Code. The trial court severed the extra-contractual claims from the contract claim. The insureds obtained a judgment on the property damage claim for \$1,746, which represented the total property damage less the insureds' deductible and the payment already received from the other driver's insurer. The jury awarded a verdict on the personal injury claim in the amount of \$9,410. Because this amount was less than the amount paid to the insureds by the other driver's insurer, the trial court entered a final judgment that the insureds take nothing on their personal injury claim against State Farm and their Article 21.55 claim. The trial court also dismissed the insureds' extra-contractual claims.

Although the trial court's order did not state the basis for the dismissal of the extra-contractual claims, the court of appeals stated that it was clear from the record that the "dismissal . . . was based on the court's determination that [the] insurance code and bad faith claims were moot."²⁵ The insureds waived their right to challenge the judgment on the Article 21.55 and breach of duty claims.²⁶ Therefore, the court of appeals addressed only the Article 21.21 claim. In addressing this claim, the court noted the principles governing the issue:

If the insurer is found liable for an amount equal to or less than its highest settlement offer, then the bad faith claims (under article 21.21) will be rendered moot This is because the extra-contractual claims are based on allegations of bad faith in investigating the plaintiff's claims and inadequate settlement offers. If an insurer prevails on liability, or if the finder of fact concludes that the plaintiff's damages do not exceed the insurer's settlement offer, then the insurer's conduct necessarily cannot have been in bad faith.²⁷

23. *Gates*, 53 S.W.3d at 830.

24. No. 96-36414-A, 2001 WL 1479228 (Tex. App.—Houston [14th Dist.] Nov. 1, 2001, no pet.) (no publication).

25. *Id.* at *2.

26. The insureds waived their challenge to the breach of good faith and fair dealing claim by failing to address the claim in their appellate brief. The insureds also waived their points of error challenging the take nothing judgment on the Article 21.55 claim because they failed to cite to the record and present arguments supporting their contentions.

27. *Id.* at *4 (citing *U.S. Fire Ins. Co. v. Millard*, 847 S.W.2d 668, 673 (Tex. App.—Houston [14th Dist.] 1993, orig. proceeding)).

Applying these principles, the Houston Court of Appeals determined that State Farm's conduct necessarily could not have been in bad faith, because State Farm was found liable for an amount less than the amount it had offered to settle the disputed claim. Accordingly, the court affirmed the trial court's judgment.

2. Tort Liability for Failure to Defend

Southstar v. St. Paul: Breach of Contractual Duty to Defend Does Not Give Rise to Tort Claims for Negligence and DTPA Violations; However, Insurer's Misrepresentations Prior to Decision Not to Defend May Give Rise to Separate Tort Action

In *Southstar Corp. v. St. Paul Surplus Lines Insurance Co.*,²⁸ the Corpus Christi Court of Appeals considered whether a tort cause of action may be brought based on an insurer's breach of its duty to defend. The insured sued its commercial general liability insurer to recover for the carrier's refusal to provide a defense in an underlying lawsuit. In addition to seeking recovery for breach of contract, the insured also alleged breach of the duty of good faith and fair dealing, misrepresentation of the policy's coverage, violation of the Deceptive Trade Practices Act ("DTPA"), and negligence. The insurer moved for summary judgment on all claims arguing that it had no duty to defend and that a tort cause of action may not be brought based on an insured's breach of the duty to defend. The district court granted summary judgment for the insurer, and the insured appealed the ruling as to the claims for negligence, violations of the DTPA, and misrepresentation.²⁹

On appeal, the court addressed the insurer's contention that a tort cause of action could not be brought based on an insured's breach of the duty to defend. The court noted that although the Texas Supreme Court has not addressed this precise issue, in *Maryland Insurance Co. v. Head Industries Coatings & Services*, the court held that "an insured is fully protected against his insurer's refusal to defend or mishandling of a third-party claim by his contractual and *Stowers* rights."³⁰ The court further noted in *State Farm Mutual Automobile Insurance Co. v. Traver*, where the allegations against the insurer arose from the insurer's own misconduct and not merely from the refusal to defend, "the claims against the insured were not limited by *Head* to the insurance policy limits and defense costs."³¹ Thus, based on *Head* and *Traver*, the court of appeals concluded that "an insured who alleges *only* that the insurer wrongfully refused a defense is limited to bringing *Stowers* claims and claims under

28. 42 S.W.3d 187 (Tex. App.—Corpus Christi 2001, no pet.)

29. *Id.* at 189.

30. *Id.* at 192 (quoting *Md. Ins. Co. v. Head Indus. Coatings & Serv., Inc.*, 938 S.W.2d 27, 28-29 (Tex. 1996)).

31. *Id.* (citing *State Farm Mut. Auto. Ins. Co. v. Traver*, 980 S.W.2d 625, 629 (Tex. 1998)).

the insurance contract.”³²

The court of appeals then looked to a sister court’s decision addressing whether a tort cause of action exists for an insurer’s wrongful refusal or failure to defend. The court noted that in *United Services Automobile Association v. Pennington*,³³ the San Antonio Court of Appeals held that in order for a tort duty to arise out of a contractual duty, the liability must arise “independent of the fact that a contract exists between the parties.”³⁴ Applying that rule to the facts in this case, the court of appeals found that the insurer’s liability for negligence did not arise independent of the insurance agreement. Rather, the insurer’s liability was based on its failure to defend or non-performance under the insurance policy. Because the act giving rise to liability for negligence was the insurer’s breach of its duty to defend under the insurance agreement, the court held that the insured’s claims for negligence and gross negligence were barred as a matter of law. Likewise, the court found that the insured’s claims under the DTPA were also linked to the breach of the duty to defend under the insurance agreement and were, therefore, barred.³⁵

The court, however, found that the insured’s misrepresentation claim was not based on the breach of the duty to defend because the insurer allegedly misrepresented the policy prior to its decision not to defend the insured. Since the misrepresentation claim did not concern the non-performance of the insurance agreement, the court held that it “may be brought independent of the claim for breach of the duty to defend under the insurance agreement.”³⁶ Accordingly, the court reversed and remanded the trial court’s granting of the summary judgment on the claim, thereby leaving open the possibility for a misrepresentation claim.³⁷

3. *No Bad Faith for Bona Fide Coverage Dispute*

King v. State Farm: Insurers May Deny Questionable Claims Without Being Subject to Liability for an Erroneous Denial of the Claim

In *King v. State Farm Mutual Automobile Insurance Co.*,³⁸ the United States District Court for the Northern District of Texas articulated the difficult burden that insureds face in proving a bad faith claim. In this case, the insured was injured in an automobile accident, then subsequently injured himself several days later by falling off a ladder at his home. Thirteen weeks after the automobile accident, the insured complained of back pain and sought extensive medical treatment for his back,

32. *Id.* at 192.

33. *United Serv. Auto. Ass’n v. Pennington*, 810 S.W.2d 777, 783-84 (Tex. App.—San Antonio 1991, no writ).

34. *Id.* (quoting *Southwestern Bell Tel. Co. v. Delanney*, 809 S.W.2d 493, 494 (Tex. 1991)).

35. *Southstar Corp. v. St. Paul Surplus Lines Ins. Co.*, 42 S.W.3d 187, 193 (Tex. App.—Corpus Christi 2001, no. pet.).

36. *Id.*

37. *Id.* at 194.

38. No. Civ. A-3:00CV2424D, 2001 WL 694576 (N.D. Tex. June 14, 2001).

including 56 sessions of physical therapy, at a cost of more than \$20,000. The insured then demanded that State Farm pay the expenses under the UM/UIM provisions of the policy. State Farm compensated the insured for his lost wages and medical expenses incurred at the hospital following the automobile accident only up to the PIP policy limit of \$2,500. However, State Farm denied the additional expenses based on its investigation of the insured's medical information and on the insured's "failure to complain of, or receive treatment for, neck or back pain until thirteen weeks after the automobile accident."³⁹

The insured sued State Farm alleging claims for breach of contract, violation of the Insurance Code, and breach of the duty of good faith and fair dealing. State Farm moved for summary judgment on the extra-contractual claims alleging that it was never able to determine that the treatment the insured received was reasonable and necessary as a result of his automobile accident. The court first addressed the bad faith claim, noting that if State Farm was entitled to summary judgment on that claim, the insured's insurance code claims would fail as well.⁴⁰ The court then discussed the difficult burden that an insured must satisfy to prevail on a bad faith claim:

In order to sustain such a claim, the insured must establish the absence of a reasonable basis for denying or delaying payment of the claim and that the insurer knew, or should have known, that there was no reasonable basis for denying or delaying payment of the claim. The insured must prove that there were no facts before the insurer which, if believed, would justify denial of the claim. However, insurance carriers maintain the right to deny questionable claims without being subject to liability for an erroneous denial of the claim. A bona fide controversy is sufficient reason for failure of an insurer to make a prompt payment of a loss claim. As long as the insurer has a reasonable basis to deny or delay payment of a claim, even if that basis is eventually determined by the fact finder to be erroneous, the insurer is not liable for the tort of bad faith.⁴¹

The court explained that "the focus of a bad faith inquiry is on the reasonableness of the insurer's conduct in rejecting or delaying payment of the claim which is determined by viewing the facts available to the insurer at the time of denial."⁴² The court noted that "an insurer will not escape liability by failing to investigate a claim so that it can contend that liability was never reasonably clear, and will breach its duty of good faith and fair dealing by failing reasonably to investigate a claim."⁴³ The court

39. *Id.* at *1.

40. *Id.* at *2 (citing *Higginbotham v. State Farm Mut. Auto. Ins. Co.*, 103 F.3d 456, 460 (5th Cir. 1997)). The court explained that under Texas law, "an insured may not prevail on a cause of action under Article 21.21 if his claim for breach of the duty of good faith and fair dealing lacks merit as a matter of law." *Id.*

41. *Id.* at *2 (citing *Arnold v. Nat'l County Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987)).

42. *Id.*

43. *King*, 2001 WL 694576, at *2.

further noted that the duty to investigate is limited, and, if, after reasonable investigation, there is evidence showing that the insured's claim may be invalid, then the insured's bad faith action is not viable. Applying these principles to the facts, the court found that there was evidence showing that the insured's claim of injury due to the automobile accident may be false and that the insured's back and neck injuries may have been caused when he fell off a ladder at his home. Accordingly, the court summarily dismissed the bad faith claim.⁴⁴

Bryan v. Zenith: No Bad Faith When Insurer Properly Investigates Claim

Although Texas courts are reluctant to dispense bad faith claims on summary judgment, it is appropriate where there is no evidence that the insurer's liability is reasonably clear nor evidence that it breached its duty to investigate a claim. *Bryan v. Zenith Insurance Co.*,⁴⁵ provides a good example of an insurer's investigation that was sufficient to preclude a finding of bad faith as a matter of law. In this case, Mary Bryan applied for survivor's benefits under the Texas Workers' Compensation Act after her husband, James Bryan, suffered a fatal heart attack on the job. Zenith Insurance Company denied coverage for the claim based on the Chief Medical Examiner's conclusion that the insured's death was caused by pre-existing heart disease. Bryan sought review of the denial of her claim through the administrative process with the Texas Workers' Compensation Commission, and the death was held to be non-compensable. Bryan then filed suit in district court seeking judicial review of the final administrative decision on the workers' compensation claim. Bryan also added a bad faith claim against Zenith regarding its claims-handling procedure. The trial court severed the bad faith claim. After a trial on the merits, the court entered judgment for Zenith on the workers' compensation claim. The court then proceeded with the bad faith claims in the severed action and granted summary judgment in favor of Zenith.⁴⁶

On appeal, Bryan argued that, despite the ruling that the claim was not covered, the bad faith claim could still exist. In addressing the bad faith claims, the Austin Court of Appeals noted that Zenith would be liable for denying the claim "if it knew or should have known that it was reasonably clear that the claim was covered."⁴⁷ Based on the facts, the court of appeals found that coverage was not reasonably clear when Zenith denied

44. *Id.* at *4 (N.D. Tex. June 14, 2001). The insured's employment records indicated that he worked 8-12 hours a day after the accident until his subsequent injury at his home. The insured also did not seek further medical treatment "until after he fell off the ladder, almost two weeks after the automobile accident, and then waited an additional eleven weeks before undergoing the medical diagnoses that were the subject of his alleged damages." *Id.*

45. No. 99-02417-A, 2001 WL 838873 (Tex. App.—Austin July 2, 2001, no pet.) (no publication).

46. *Id.* at *1.

47. *Id.* at *3 (citing *Universe Life Ins. Co. v. Giles*, 950 S.W.2d 48, 56 (Tex. 1997)).

the claim. Specifically, the court noted that Zenith initially denied the claim based on the autopsy report, which indicated that heart disease was the cause of death. The court further noted that Zenith sought a second and third medical opinion, which confirmed the cause of death was from heart disease. Because the three medical opinions provided a reasonable basis for Zenith's conclusion that James Bryan's heart attack was the result of heart disease instead of a work-related event, the court held "that there could be no claim that liability was reasonable clear, as required for a holding of bad faith."⁴⁸

As another ground for asserting a bad faith claim, Bryan alleged that Zenith failed to properly investigate the claim by failing to investigate the issue of James Bryan's physical exertion on the day of his death. The court of appeals acknowledged that although liability must be reasonably clear before an insurer's denial is deemed in bad faith, insurers have a duty to properly investigate claims. The court of appeals further noted that "[i]nsurers may not neglect investigation so as to prevent liability from ever becoming reasonably clear."⁴⁹ The court explained that an insurance company breaches its duty of good faith and fair dealing if it fails to reasonably investigate a claim. Thus, despite the determination that the claim was not covered, the court evaluated Bryan's claim that Zenith breached its duty by failing to obtain an alleged videotape from the deceased's employer or other related evidence. The court found that Zenith had requested the alleged videotape from the deceased's employer but was never furnished the tape. Because there was no evidence that the tape existed, the court held that Zenith could not have acted in bad faith by failing to procure the tape. Accordingly, the court of appeals affirmed the district court's judgment.⁵⁰ It is interesting to note that the court of appeals went on to address the merits of the extra-contractual claims, despite the fact that the workers' compensation claim was previously resolved against the insured. This might suggest that the court considered the possibility that extra-contractual liability could exist in the absence of contractual liability.

4. *Duty of Good Faith and Fair Dealing Extends Beyond Judgment Against Insurer*

Mid-Century v. Boyte: Duty of Good Faith and Fair Dealing Extends Beyond Judgment on Insured's UIM Claim

During the Survey period, the Fort Worth Court of Appeals held that an insurer's duty of good faith and fair dealing extends beyond a judgment on its insured's UIM claim in *Mid-Century Insurance Co. of Texas v. Boyte*.⁵¹ This case arose in 1992 when the insured, Randy Boyte, was in-

48. *Id.* at *3-4.

49. *Id.* at *4 (citing *Giles*, 950 S.W.2d at 56).

50. *Bryan*, 2001 WL 838873, at *4.

51. *Id.*

volved in a car accident. Boyte made a claim against his insurer, Mid-Century, for personal injury protection ("PIP") and also asserted a liability claim against the other driver. Boyte filed suit against the other driver, and her carrier tendered its policy limits of \$100,000 to Boyte. Boyte then added Mid-Century to the underlying lawsuit asserting claims for UIM benefits.

In 1995 Mid-Century determined that Boyte's UIM claim was worth \$120,000 and tendered \$20,000, which was the difference after subtracting the settlement with the other driver. Because Boyte needed additional medical treatment, his claims against Mid-Century for the remaining policy limits proceeded to trial.⁵² The jury found that Boyte was entitled to the remaining \$80,000 available under the Mid-Century policy, and Mid-Century appealed the judgment. After the judgment, Boyte informed Mid-Century that he was in need of back surgery and he could not afford it.⁵³ Despite the \$80,000 judgment for Boyte, Mid-Century only offered to pay \$23,400 for Boyte's back surgery and therapy since the appeal was pending. Boyte declined this offer, and Mid-Century did not pay the \$80,000 until 1998, after the Court of Appeals affirmed the trial court's judgment and the Texas Supreme Court denied review.

As a result of Mid-Century's delay in settling his claim, Boyte sued Mid-Century for bad faith, breach of fiduciary duty, and violations of the Insurance Code and the DTPA. The case proceeded to trial, and the jury found that Mid-Century knowingly failed to attempt to effectuate a prompt, fair, and equitable settlement of Boyte's claim when it knew or should have known that its liability was reasonably clear. Mid-Century appealed arguing, among other things, that the duty of good faith and fair dealing does not extend beyond judgment. Specifically, Mid-Century alleged that "it and Boyte [were] no longer in an insurer-insured relationship but that they [were] in a judgment debtor-creditor relationship since Boyte obtained a judgment against Mid-Century."⁵⁴ In support of its argument, Mid-Century relied on *Stewart Title Guaranty Co. v. Aiello*,⁵⁵ in which the Texas Supreme Court held that an insurance company does not owe a duty of good faith and fair dealing on a claim when the claim has already been settled by both parties. The Court of Appeals affirmed the trial court's judgment finding that the facts were distinguishable from *Aiello* because the agreed judgment in *Aiello* was subject to immediate execution, while the judgment in this case was superseded pending Mid-

52. *Mid-Century*, 49 S.W.3d at 410.

53. *Mid-Century*, 2002 WL 1027985, at *1.

54. *Mid-Century*, 49 S.W.3d at 413.

55. See *Mid-Century*, 49 S.W.3d at 413 (citing *Stewart Title Guar. Co. v. Aiello*, 941 S.W.2d 68 (Tex. 1997)). The *Aiello* case dealt with a policyholder who settled his claim and entered into an agreed judgment that was not suspended by any appeal and became final. It was not until the insurer failed to perform according to the judgment that the Aiellos attempted to assert a claim for breach of the duty of good faith and fair dealing. Accordingly, the Texas Supreme Court held that an insurance company did not owe a duty of good faith and fair dealing on a claim when the claim had already been settled.

Century's appeal.⁵⁶

On May 23, 2002, the Texas Supreme Court reversed the court of appeals' holding. In reaching its decision, the Texas Supreme Court held that the facts in this case were not distinguishable from *Aiello*. In particular, the Texas Supreme Court noted that "[l]ike the agreed judgment in *Aiello*, Mid-Century's UIM judgment called only for payment of a sum of money to Boyte."⁵⁷ The Supreme Court held that the parties' relationship was transformed from one of insurer-insured to judgment creditor-judgment debtor upon the trial court's entry of judgment.⁵⁸ The Court explained that "an insurer's duty of good faith arises because of the disparity in bargaining power inherent in the insurer-insured relationship," which "simply [does] not arise in the judgment creditor—judgment debtor context."⁵⁹ The Supreme Court held that Boyte, like the Aiellos, was not vulnerable because he had access to a number of enforcement remedies.⁶⁰ Thus, the Supreme Court held that Boyte had no bad faith cause of action based on Mid-Century's post-judgment conduct because the judgment extinguished Mid-Century's duty of good faith.⁶¹

5. *Interpleading Funds for Conflicting Claims*

First Colony v. Bailey-Mason: Insurer Avoids Bad Faith Claim by Interpleading Funds for Conflicting Claims

*First Colony Life Insurance Co. v. Bailey-Mason*⁶² illustrates an insurer's effective use of an interpleader action to avoid bad faith claims when it is presented with conflicting claims. First Colony Life Insurance Co. ("First Colony") issued a life insurance policy to Edward James Mason, Jr., in the amount of \$100,000. In 1999, Mason died as a result of multiple gunshot wounds. Carlyn Bailey-Mason, the insured's primary beneficiary under the policy, submitted a claim to First Colony under the policy. Upon investigating the claim, First Colony learned that the police department's investigation into the insured's murder was ongoing and that Bailey-Mason had not been eliminated as a suspect. First Colony also learned that the insured's divorce from his first wife, Rae Mason, may never have been finalized. Based on these facts, First Colony filed an interpleader action, pleading that Bailey-Mason had not been eliminated as a suspect and that her interest as a beneficiary in the Policy would be forfeited if she had willfully brought about the death of the insured. First Colony further pleaded that Rae Mason might have a community property interest in the policy or premiums if she and the insured never divorced. Both Bailey-Mason and Rae Mason appeared and as-

56. *Id.*

57. *Mid-Century*, 2002 WL 1027985, at *2.

58. *Id.*

59. *Id.*

60. *Id.*

61. *Id.* at *3.

62. No. Civ. A. 3:00CV1417M, 2001 WL 705786 (N.D. Tex. June 18, 2001, no pet.).

serted claims for the proceeds of the policy. Bailey-Mason also asserted counterclaims against First Colony alleging bad faith.⁶³

In evaluating Bailey-Mason's counterclaim, the court noted that in order for Bailey-Mason to prevail on her bad faith claim, she must establish that First-Colony knew or should have known that it was reasonably clear that her claim was covered under the Policy. The court further noted that an insurer is not liable for statutory penalties and attorney fees for interpleading insurance proceeds due to conflicting claims.⁶⁴ The court also explained the insurer's liability for interest ceases once it makes an unconditional tender of funds.⁶⁵ Accordingly, the court held that First Colony was not liable for statutory penalties and attorneys' fees, because it had a reasonable basis for declining the claim and for interpleading the policy proceeds.

B. STOWERS CLAIMS

1. Standing

Balog v. State Farm: Injured Third Party Has No Standing to Assert Stowers Claim Against Carrier Absent Assignment of Claim from Insured

In *Balog v. State Farm Lloyds*,⁶⁶ the El Paso Court of Appeals addressed whether an injured third party had standing to assert a *Stowers* action against an insured's carrier absent an assignment. This case arose after Kay Balog sustained severe injuries when Mark Mitchell struck her head with a baseball bat during the course of a robbery. As a result, Mitchell was convicted for attempted capital murder and was sentenced to serve six years in prison. Following Mitchell's conviction, Balog filed suit against Mitchell and his parents. The Mitchells requested that State Farm provide a defense under their homeowner's policy. State Farm initially agreed to provide a defense subject to a reservation of rights, but it later obtained a declaratory judgment that it had no duty to defend because the policy excluded intentional conduct from coverage. Balog obtained a judgment against Mitchell in the underlying litigation for \$2.72 million.⁶⁷

Balog then filed suit against State Farm seeking to recover that portion of the judgment within the policy limits (\$300,000). Balog also sought to recover the amount awarded by the jury in excess of the policy limits pursuant to the *Stowers* doctrine for State Farm's refusal of her prior demand to settle for policy limits. State Farm answered and, with the trial

63. *Id.* at *1.

64. *Id.* at *4 (citing *Murphy v. Travelers Ins. Co.*, 534 F.2d 1155, 1163-64 (5th Cir. 1976) and *Cable Comm. Network, Inc. v. Aetna Casualty & Surety Co.*, 838 S.W.2d 947, 950 (Tex. App.—Houston [14th Dist.] 1992, no writ)).

65. *Id.* at *4 (citing *Murphy v. Travelers Ins. Co.*, 534 F.2d 1155, 1163-64 (5th Cir. 1976)).

66. No. 08-00-00324-CV, 2001 WL 997412 (Tex. App.—El Paso Aug. 30, 2001, no pet. h.) (no publication).

67. *Id.* at *1.

court's consent, filed a third-party declaratory judgment action against Mitchell seeking a determination that it had no duty to indemnify him for the underlying judgment. Mitchell failed to answer, and the trial court rendered a default declaratory judgment in favor of State Farm.⁶⁸ State Farm then moved for summary judgment against Balog, and the trial court granted the summary judgment in State Farm's favor.⁶⁹

On appeal, Balog alleged that State Farm wrongfully refused to settle her claim against Mitchell. However, State Farm argued that the *Stowers* claim must fail because Balog failed to present evidence that she obtained an assignment of the claim from Mitchell. The court noted that "a claim that an insurer negligently failed to settle an injured party's action against an insured belongs to the insured, and the injured party has no standing to assert it absent an assignment of the claim."⁷⁰ The court held that Balog lacked standing to assert the claim, because she failed to produce evidence that she had been assigned Mitchell's *Stowers* claim. Accordingly, the court affirmed the trial court's judgment.⁷¹

2. Effect of Bankruptcy

Davis v. Osherow: No Stowers Liability Where Insured's Liability is Discharged in Bankruptcy Before Judgment Becomes Final

In *Davis v. Osherow*,⁷² the Fifth Circuit addressed whether a *Stowers* claim exists where the insured is not personally liable for a judgment. In this case, the insured was involved in an automobile accident that resulted in injuries to David Baker, a passenger in the insured's vehicle. The Bakers filed suit against the insured, and the insured's automobile insurance carrier, Safeway Managing General Agency, Inc., provided a defense for the insured. The Bakers made a settlement demand to Safeway, but Safeway never responded. Safeway intervened in the litigation and interpleaded the entire bodily injury limits available under the insured's policy. The Bakers asserted a *Stowers* cause of action against Safeway for negligently failing to settle claims within the policy limits.⁷³

On the day the trial was set in the underlying tort lawsuit, the insured filed for Chapter 7 Bankruptcy protection, and the bankruptcy court granted the insured's bankruptcy discharge. The Bakers filed a proof of claim in the bankruptcy case, alleging an unsecured, non-priority claim in the amount of \$2,300,000 for alleged damages arising as a result of the accident.⁷⁴ The Bakers' action against the insured was tried on January

68. For discussion of the declaratory judgment, see *supra* part III.B.3.

69. *Balog*, No. 08-00324-CV, 2001 WL 997412 (Tex. App.—El Paso Aug. 30, 2001, no pet. h.) (no publication).

70. *Id.* at *2 (citing *Whatley v. City of Dallas*, 758 S.W.2d 301, 307 (Tex. App.—Dallas 1988, writ denied)).

71. *Id.*

72. 253 F.3d 807 (5th Cir. 2001).

73. *Id.* at 808.

74. *Id.* at 809.

26, 1998, and a verdict was rendered in favor of the insured. The trial court granted a new trial, and the case was retried. A verdict was eventually rendered against the insured in the amount of \$550,000. After the first verdict, but before the retrial of the action, Safeway filed an adversary action in the bankruptcy court against the trustee and the Bakers, seeking a declaratory judgment that no *Stowers* claim existed in the bankruptcy estate against Safeway. The bankruptcy court tried the adversary action and a final judgment was entered declaring that a *Stowers* cause of action existed and was owned by the bankruptcy estate.⁷⁵

Safeway appealed to the Fifth Circuit arguing that the bankruptcy court erred in ruling that a *Stowers* claim could exist in favor of the estate. Specifically, Safeway argued that under Texas law, a *Stowers* claim does not accrue until a judgment is entered in excess of policy limits, and the estate had no *Stowers* claim in this action, because such judgment was not entered until three years after the insured filed for bankruptcy protection. Safeway also argued that the insured's bankruptcy discharge nullified any potential for a *Stowers* claim or any injury giving rise to a *Stowers* claim. In reaching its decision, the Fifth Circuit noted that "a *Stowers* cause of action does not accrue until the judgment in the underlying case becomes final."⁷⁶ Thus, the court held that since there was no judgment against [the insured] until July 27, 1999, more than three years after the commencement of the bankruptcy case, [the insured] could not have had a *Stowers* claim against [Safeway] before that date because the "tort was not complete."⁷⁷ In addition, because the insured did not have such a claim at the time of the commencement of his bankruptcy action, such claim also could not have been included in the estate. Moreover, the Court found that the insured's bankruptcy discharge more than two years prior to the judgment in the Baker's action negated the existence of a *Stowers* claim because there was no subsequent harm or legal injury to the insured because he is no longer personally liable to the Bakers for any judgment in excess of the amount covered by the insurance policy as a result of the discharge.⁷⁸

C. PROMPT PAYMENT ACT (ARTICLE 21.55)

1. No Penalty Absent Liability for Claim

Allstate v. Bonner: No Liability for Penalties for Failing to Timely Acknowledge a Claim Absent Proof of Liability for the Claim

In *Allstate Insurance Co. v. Bonner*,⁷⁹ the Texas Supreme Court considered whether an insurer's failure to timely acknowledge a claim entitles

75. *Id.*

76. *Id.* (citing *Street v. Hon. Second Ct. of Apps.*, 756 S.W.2d 299, 301 (Tex. 1988)).

77. *Davis*, 253 F.3d at 810 (quoting *Linkerhoger v. Am. Fid. & Cas. Co.*, 260 S.W.2d 884, 887 (Tex. 1953)).

78. *Id.* at 810.

79. 51 S.W.3d 289 (Tex. 2001).

the insured to a penalty under Texas Insurance Code Article 21.55, Section 6, even if the insurer was not ultimately liable for the claim presented. In this case, the insured was injured in an accident caused by an uninsured motorist. The insured submitted notice for a personal injury protection (“PIP”) benefits claim, and Allstate paid \$1,619 of the PIP claim. The insured then made a claim for uninsured motorist (“UM”) benefits claim under the same policy. Allstate failed to acknowledge receipt of the UM claim within fifteen days and eventually denied the claim. As a result, the insured sued Allstate to recover the UM benefits and statutory penalties under Article 21.55 based on Allstate’s failure to timely acknowledge the claim. Although Allstate stipulated that it failed to timely acknowledge receipt of the demand, it defended the claim based on the undisputed fact that it had already paid PIP benefits in excess of the UM claim.⁸⁰

The jury found UM damages in an amount less than the PIP payment, but awarded the insured attorneys’ fees under Article 21.55. The trial court declined to award attorneys’ fees based on the non-duplication provision and rendered a judgment that the insured take nothing. The court of appeals affirmed the take nothing judgment, but reversed the trial court’s denial of attorney’s fees and assessed all costs of court for trial and appeal against Allstate based on its failure to comply with Article 21.55.⁸¹

Allstate appealed to the Texas Supreme Court, arguing that the insured was not entitled to attorneys’ fees, because Article 21.55, section 6, only penalizes insurers when they fail to acknowledge claims for which they are liable. Allstate argued that it was not liable for the insured’s UM claim, because the nonduplication-of-benefits provision entitled the insured to UM benefits only if her UM damages exceeded those paid or payable under the policy’s PIP coverage. The court agreed, stating that Article 21.55 provides a statutory penalty and reasonable attorney’s fees “in all cases where a claim is made pursuant to a policy of insurance and the insurer liable therefore is not in compliance with [the article].”⁸² The Court further noted that “[t]o successfully maintain a claim under Section 6, a party must establish three elements: (1) a claim under an insurance policy; (2) that the insurer is liable for the claim; and (3) that the insurer has failed to follow one or more sections of Article 21.55 with respect to the claim.”⁸³ The Texas Supreme Court found that Allstate successfully defeated the insured’s claim and, therefore, the insured failed to establish the second requirement. As a consequence, the Texas Supreme Court held that Allstate was not liable for the statutory penalties under 21.55 despite the fact that it failed to comply with Article 21.55.

80. *Id.* at 290. Allstate defended the claim based on the policy’s non-duplication of benefits provision, which entitled the insured to UM benefits only if the UM damages exceeded damages paid under the PIP coverage.

81. *Id.*

82. *Id.* (citing TEX. INS. CODE art. 21.55, Section 6 (Vernon Supp. 2000)).

83. *Id.*

2. Severance from Contract Claims

In re Trinity: Court Abused Discretion in Denying Severance of Prompt Payment Claims from Contract Claim

In *In re Trinity Universal Insurance Co.*,⁸⁴ the Seventh Court of Appeals in Amarillo held that prompt payment claims under Texas Insurance Code Article 21.55 must be severed from unadjudicated uninsured/underinsured motorist claims. This case arose after the insured sustained fatal injuries in a head on collision with a motorized work over rig owned and operated by an employee of Premier Well Service, Inc. ("Premier"). After the insureds filed their petition in the underlying action against Premier and its employee and discovered that the limits of liability insurance for Premier did not exceed one million dollars, the insureds made a written claim for UIM benefits against Trinity Universal Insurance Company on April 18, 2000.⁸⁵

The insureds then joined Trinity as a defendant and asserted several claims pursuant to the policy, including claims under the UIM endorsement, breach of good faith and fair dealing, and Article 21.55 of the Insurance Code. The insureds eventually settled and dismissed their claims against Premier and the operator of its equipment. Trinity filed a motion for severance and abatement, which the trial court partially granted. The trial court severed the bad faith and Article 21.21 claims, but denied severance of the Article 21.55 claim. Trinity then sought a writ of mandamus to compel the trial judge to grant its motion for severance regarding the Article 21.55 claim.⁸⁶

Trinity asserted two grounds in support for the severance. First, Trinity argued that the UIM claim should have been severed from the extra-contractual claims "because evidence of settlement negotiations and insurance policy limits may be relevant to the extra-contractual claims but is not admissible as to the UIM claims."⁸⁷ Second, Trinity argued that it "should not be required to undergo the expense of discovery as to the extra-contractual claims, when there is a substantial possibility that the damages awarded in the contract claim will not exceed the limit of the tortfeasor's policy, and thus will not even trigger the UIM endorsement, which would preclude any necessity to discover or litigate the extra-contractual claims."⁸⁸ The court found that the claim for damages under Article 21.55 was severable, because (1) the claim for UIM benefits was contractual and the claim for penalties under 21.55 controversy involves more than one cause of action, (2) the severed claim was one that would be the proper subject of a lawsuit if independently asserted, and (3) the

84. No. 07-01-0377-CV, 2001 WL 1338798 (Tex. App.—Amarillo Oct. 30, 2001, orig. proceeding).

85. *Id.* at *1.

86. *Id.*

87. *Id.* at *2.

88. *Id.*

Article 21.55 claim is not so interwoven with the tort action and contract action that they involve the same facts and issues.⁸⁹ The court further found that Trinity had no adequate remedy at law. Accordingly, the court held that the trial court abused its discretion in denying the severance and granted the petition for writ of mandamus requiring the trial court to grant the motion to sever the Article 21.55 claim from the contract claim.

3. *Insurer's Innocent Mistake Results in Penalties*

American National v. Patty: Insurer's Misunderstanding of Law Results in Statutory Penalties

*American National Property & Casualty Co. v. Patty*⁹⁰ illustrates how an insurer's mistake can result in penalties under Article 21.55. In this case, the insureds executed a "Bill of Sale" to sell their home to buyers for \$28,000. After making several payments, the buyers notified the insureds that they no longer wished to buy the home, ceased making payments, and returned the keys. Approximately two weeks later, a fire completely destroyed the home. The insureds made a claim on their property insurance issued by American National. Because the policy contained a provision limiting its liability to the policyholder's interest in the property, American National offered to pay the insureds only \$12,000, which was the amount the buyers owed on the home. The insureds rejected the offer, contending that they were entitled to the full policy limits of \$75,300. American National filed a declaratory judgment action, and the insureds counter-claimed for a declaration that American National owed policy limits, as well as damages for violations of the Insurance Code. The trial court ruled that the Bill of Sale was a contract for deed that the buyers had repudiated before the fire. Therefore, the trial court held that the insureds were entitled to the policy limit of \$75,300, less the deductible, and awarded the insureds statutory penalties under Article 21.55.

At trial and on appeal, American National argued that the insureds were not full owners of the property but were mortgagees, and that \$12,000 was the extent of their insurable interest. The Dallas Court of Appeals disagreed finding that the Bill of Sale was executory in nature, setting out future obligations, and was a contract for deed. The court found that the buyers had rescinded the contract of sale when they returned the keys to the insureds and, therefore, any interest the buyers had in the property was extinguished at that time. The court affirmed the trial court's holding that the insureds were entitled to the policy limits less their deductible. The court also held that American National was liable for penalties under Article 21.55 as a result of its delay in making pay-

89. *In re Trinity Universal Ins. Co.*, 2001 WL 1338798, at *4.

90. No. 05-00-01171-CV, 2001 WL 914990 (Tex. App.—Dallas Aug. 15, 2001, no pet. h.) (no publication).

ments to the insureds.⁹¹

III. CONTRACTUAL LIABILITY

A. CGL POLICIES

1. "Occurrence"

During 2001, several Texas courts addressed whether third party claims against insureds involved "occurrences" under the respective commercial general liability policies at issue. The courts struggled with construing the definition of "occurrence" in general liability policies in the context of construction defect cases. Several cases determined that damages resulting from a builder's substandard construction or failure to comply with specifications were the natural and probable consequence of the builder's intentional acts and, therefore, did not constitute an "occurrence." On the other hand, at least one case held that damages resulting from a builder's failure to construct a home in a good and workmanlike manner arose from the builder's negligence and did constitute an "occurrence." Although these opinions appear to reach inconsistent results, the reasoning applied appears to be consistent with the principle explained in the Fifth Circuit Court of Appeals' decision in *Harken Exploration Co. v. Sphere Drake Insurance PLC*, which is discussed below. Thus, despite the differing outcomes, the decisions are not necessarily in conflict.

Harken v. Sphere Drake: Property Damage and Pollution Arising from Operation of Oil Facility Deemed to Constitute an "Occurrence" Triggering Coverage

In *Harken Exploration Co. v. Sphere Drake Ins. PLC*,⁹² the Fifth Circuit addressed whether pollution claims against an insured constituted an "occurrence" within the meaning of the insured's liability policies. The insured in this case purchased and commenced oil and gas operations on an oil and gas lease. The owners of a nearby ranch, the Rices, sued the insured in federal court alleging causes of action for breach of the lease, breach of the pipeline easement, negligence, and violation of the Oil Pollution Act. The insured asked its insurer, The Sphere Drake Insurance Company ("Sphere"), to defend it in the lawsuit under its commercial general liability policy, and Sphere refused to provide a defense. The insured filed a declaratory judgment action to determine whether Sphere had a duty to defend it in the federal lawsuit. The Rices' claim under the Oil Pollution Act was eventually dismissed and the state law claims were dismissed for want of jurisdiction. The Rices then sued the insured in state court alleging the same state law claims. In the declaratory judg-

91. *Id.* at *4. The court, however, noted that interest had been calculated incorrectly and reformed the judgment to reflect the proper interest calculation.

92. 261 F.3d 466 (5th Cir. Tex. 2001).

ment action against Sphere, the court found in favor of the insured.⁹³

In determining whether Sphere had a duty to defend, the Fifth Circuit first looked to whether the Rices had alleged an occurrence within the policy. The court noted that the policies defined occurrence as “an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured.”⁹⁴ Because the policies did not define “accident,” the court considered the general rules cited by the Texas Supreme Court and the Fifth Circuit:

The Texas Supreme Court has told us that there is not an accident when the action is intentionally taken and performed in such a manner that it is an intentional tort, regardless of whether the effect was unintended or unexpected We also know, however, that there is an accident when the action is intentionally taken, but is performed negligently, and the effect is not what would have been intended or expected had the action been performed non-negligently *In other words, if the act is deliberately taken, performed negligently, and the effect is not the intended or expected result had the deliberate act been performed non-negligently, there is an accident.*⁹⁵

The Fifth Circuit noted the Rices alleged that (1) the lines, tanks, and wells on the property subject to the lease had ruptured, leaked and overflowed and continued to do so; (2) the pollutants released had contaminated the ranch and damaged plant and animal life; and (3) the insured negligently, carelessly, and wrongfully polluted the ranch and acted maliciously with intent and awareness that its actions would cause property damage.⁹⁶ Applying the general rules to the facts, the Fifth Circuit found that the Rices alleged an accident, which would constitute an occurrence under the policies. Specifically, the Fifth Circuit held that “the operation of the oil facilities is the action deliberately taken, but alleged to have been performed negligently,” and the damage to plant and animal life caused by the pollutants was “the unintended and unexpected effects of the non-negligent operation of an oil facility.”⁹⁷

Malone v. Scottsdale: Damages Resulting from Builder’s Failure to Construct Home in Compliance with Warranties and Architect’s Specifications Do Not Constitute an “Occurrence”

In *Malone v. Scottsdale Insurance Co.*,⁹⁸ the United States District Court for the Southern District of Texas held that a contractor’s failure to construct improvements in accordance with the architect’s plans and specifications was not an “occurrence.” The insured, Malone Construction Company (“Malone”), contracted with a partnership to construct

93. *Id.* at 470.

94. *Id.* at 472.

95. *Id.* at 472-73 (emphasis added).

96. *Id.*

97. *Harken Exploration Co.*, 261 F.3d at 474.

98. 147 F. Supp. 2d 623 (S.D. Tex. 2001).

commercial improvements to an office and warehouse complex in Conroe, Texas. The partnership then sued Malone alleging negligent construction of improvements to real property. In support of its claim, the partnership set forth an extensive list of Malone's failures to properly construct the improvements, naming over forty defects in Malone's work. The trial court eventually entered judgment against Malone for \$178,909 in actual damages, \$75,000 in attorney's fees and \$72,249 in pre-judgment interest, in addition to post-judgment interest and costs of court.⁹⁹

At the time of the lawsuit, Malone was insured under a commercial general liability policy issued by Scottsdale. The Policy contained several exclusions for property damage caused by faulty workmanship. Malone sought a defense under the Scottsdale policy, and Scottsdale denied coverage. Malone sued Scottsdale seeking the costs of his defense and indemnity in the underlying lawsuit. Scottsdale moved for summary judgment on the grounds that the property damage was not caused by an "occurrence" as that term was defined in the policy.¹⁰⁰

In addressing whether the claim constituted an "occurrence," the court first looked to the policy. The policy defined an "occurrence" as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions."¹⁰¹ The court noted that under Texas law, an injury is accidental if "from the viewpoint of the insured, [it is] not the natural and probable consequence of the action or occurrence which produced the injury."¹⁰² The court then looked to a sister court's decision addressing whether a builder's failure to comply with implied warranties constituted an occurrence under a similar policy. The court noted that in *Hartrick v. Great American Lloyds Ins. Co.*, the Houston Court of Appeals concluded that the builder's "[l]ack of compliance with implied warranties, i.e., promises implied as a matter of law, are not accidental, but resulted from not doing what one must do."¹⁰³ Thus, the *Hartrick* court held that when "an injury results from voluntary and intentional conduct, here, not preparing the soil and not constructing the foundation in keeping with the promises implied on [the builder] by law, the injury is not an 'accident' and, therefore, not an 'occurrence.'"¹⁰⁴

The court noted that the petition alleged that Malone "failed to construct improvements in accordance with the architect's plans and specifications"¹⁰⁵ that were approved by the city. Relying on *Hartrick*, the court concluded that "these failures were omissions that can only be considered

99. *Id.* at 626.

100. *Id.* at 627. Scottsdale also argued that the policy contained several exclusions for property damage caused by the insured's faulty workmanship.

101. *Id.* at 627.

102. *Id.* at 627 (citing *Mid-Century Ins. Co. v. Lindsey*, 997 S.W.2d 153, 155 (Tex. 1999)).

103. *Id.* at 628 (citing *Hartrick v. Great Am. Lloyds Ins. Co.*, 62 S.W.3d 270 (Tex. App.—Houston [1st Dist.] 2000, no writ)).

104. *Id.* at 627 (citing *Hartrick*, 62 S.W.3d at 277)).

105. *Malone*, 147 F. Supp. 2d at 627.

voluntary and intentional, as opposed to accidental.”¹⁰⁶ The court opined that “By not doing what it had to do, [the builder] could reasonably anticipate injury to [the plaintiffs.]”¹⁰⁷ The court further held that the fact that the petition alleged “negligent” construction of improvements to real property did not alter its conclusion. Accordingly, the court held Malone was not entitled to coverage, because there was no “occurrence” under the policy.¹⁰⁸

Devoe v. Great American: Damages from Builder’s Defective Construction Arose From Intentional Act and Do Not Constitute an Occurrence.

In *Devoe v. Great American Insurance*,¹⁰⁹ the Austin Court of Appeals applied a similar interpretation of the term “occurrence.” The Devoes sued their homebuilder, Tri-Mark, for defective construction alleging breach of contract and violations of the DTPA. Tri-Mark requested that Great American defend and indemnify it under its CGL policy, and Great American declined to defend. Tri-Mark failed to appear for trial, and the court granted a default judgment against Tri-Mark “for actual damages of \$216,035.13, attorney’s fees in the amount of \$27,173.23, and post-judgment interest.” Tri-Mark failed to satisfy the judgment, and the Devoes sued Great American, seeking recovery as third-party beneficiaries under the policy. The trial court granted summary judgment in favor of Great American.¹¹⁰

The issue on appeal was whether the claim alleged an “occurrence” under the Policy. In addressing this point, the Austin Court of Appeals stated:

A review of the Devoes’ claim for relief did not turn on any alleged “occurrence” as required by the Policy. In applying the eight-corners test to this case, the Devoes’ allegations must state a claim that is potentially within the coverage of the Policy. The damages complained of by the Devoes concentrate on Tri-Mark’s defective construction. While the Devoes’ allegations are to be liberally construed, we are not obligated to imagine factual scenarios that could potentially bring the claim within the policy limits They do not allege any event or series of events that could be construed as an accident. The Devoes’ home was constructed over a period of time as a voluntary and intentional act by the insured, and the alleged deficient and substandard construction did not constitute an accident or an occurrence under the plain-meaning rule even if the resulting, poorly constructed home was unexpected, unforeseen, or unintended by the insured.¹¹¹

106. *Id.*

107. *Id.* at 628 (citing *Hartrick*, 62 S.W.3d at 278)).

108. *Malone*, 147 F. Supp. 2d at 628.

109. 50 S.W.3d 567 (Tex. App.—Austin 2001, no. pet.).

110. *Id.* at 569.

111. *Id.* at 572 (citations omitted).

The court concluded that the allegations in the pleadings did not allege an “occurrence” that would trigger Great American’s duty to defend under the policy. Accordingly, the court affirmed the summary judgment in favor of Great American.¹¹² At first glance, this holding appears to be inconsistent with the holding in *Hartrick* because the builder did not expect, foresee, or intend the damage to the home. However, since the resulting damage was the natural and probable consequence of the builder’s intentional and voluntary failure to construct the improvements in accordance with the architect’s plans and specifications, the decision follows the principles articulated in *Harken*, *Hartrick* and *Malone*.

First Texas Homes v. Mid-Continent: Builder’s Liability for Failure to Construct Home in Good and Workmanlike Manner Deemed to be Accidental Occurrence Triggering Coverage.

On the other hand, in *First Texas Homes, Inc. v. Mid-Continent Casualty Co.*,¹¹³ a Texas federal court held that allegations of negligent workmanship were broad enough to allege an “occurrence,” thereby giving rise to the duty to defend. In this case, a homeowner sued his builder, First Texas, alleging that the home was not constructed in a good and workmanlike manner and that the foundation was insufficient. First Texas’ insurer, Mid-Continent Casualty Company, refused to provide a defense on the grounds that the petition did not allege an occurrence under the policy. “First Texas then filed [a] declaratory judgment action to determine the respective rights and duties of the parties under the policy.”¹¹⁴

The issue in the declaratory judgment action was whether the insurer had a duty to defend First Texas in the underlying litigation. The policy defined “occurrence” to mean “an accident, including continuous or repeated exposure to substantially the same general harmful conditions.”¹¹⁵ The court noted that “[c]ourts have interpreted the term ‘accident’ in this context to include damage that is the ‘unexpected, unforeseen or undesigned happening or consequence of an insured’s negligent behavior.’”¹¹⁶ The court then looked to a Fifth Circuit decision holding that “defective performance or faulty workmanship by the insured that injures the property of a third party is ‘accidental under this definition.’”¹¹⁷ The court noted that “a builder who failed to abide by the specifications of a contract, for example by substituting a weaker building material, may, by that breach, produce expected property damage to his or her work, and

112. *Id.*

113. No. 3-00-CV-1048-BD, 2001 WL 238112 (N.D. Tex. March 7, 2001).

114. *Id.* at *1.

115. *Id.*

116. *Id.* at *2 (citing *Federated Mut. Ins. Co. v. Grapevine Excavation, Inc.*, 197 F.3d 720, 725 (5th Cir. 1999)) (other citations omitted) (emphasis added).

117. *First Tex. Homes, Inc.*, 2001 WL 238112, at *2 (citing *Hartford Cas. Co. v. Cruse*, 938 F.2d 601, 604-05 (5th Cir. 1991)) (other citations omitted).

may thus fail to show a covered ‘occurrence.’”¹¹⁸ The court explained that “the relevant inquiry is not whether the insured damaged his own work, but whether the resulting injury or damage was unexpected and unintended.”¹¹⁹

In this case, the petition alleged that the home was “not of proper quality and was not designed or constructed in a good and workmanlike manner and that the foundation was insufficient and resulted in a foundation and home that were not properly designed or built.”¹²⁰ The court noted that the allegations were broad and any doubts about whether the petition alleged a covered cause of action must be resolved in favor of the insured. Thus, the court concluded that the broad allegations could be construed to support a claim that the damages were neither expected nor intended by First Texas. Accordingly, the court held that the petition alleged an “occurrence” and that Mid-Continent had a duty to defend. While this decision appears to be in conflict with the previously cited cases, it is important to note that this case was a duty to defend case and the court broadly construed the allegations in favor of the insured. Furthermore, this case illustrates the principle articulated in *Harken*, “that there is an accident when the action is intentionally taken, but is performed negligently, and the effect is not what would have been intended or expected if the action had been performed non-negligently.”¹²¹ Thus, since there were no allegations indicating that the insured expected or intended the damage or that the damages were the natural and probable result of the insured’s intentional conduct, this decision arguably can be reconciled with the other construction cases discussed above.

Martin v. St. Paul: Water User Deemed to be Aware of Impact of Diversion on Downstream Users; Therefore, Liability for Deprivation to Other Users Does not Constitute Covered “Accident”

In *Martin Marietta Materials Southwest, Ltd. v. St. Paul Guardian Insurance Co.*,¹²² a Texas federal court addressed whether the intentional diversion of water triggers coverage under a general liability policy. This case arose when the insured, an upstream facility, “diverted [a] creek to dredge, wash, and screen sand and gravel for on-site construction” without a permit. As a result, Trinity Materials, Inc. (“Trinity”), a downstream facility holding senior water rights, sued the insured alleging that the insured “deprived Trinity of water, which it needed to operate.” Trinity asserted that the insured’s diversion caused production and sales losses exceeding \$150,000. The insured filed a declaratory judgment action against its insurer seeking a declaration that Trinity had a duty to

118. *Id.* at *3 (emphasis removed).

119. *Id.* (citing *Cruse*, 938 F.2d at 604-05).

120. *Id.* at *3.

121. *Harken Exploration Co.*, 2001 WL 868275, at *3 (citation omitted).

122. 145 F. Supp. 2d 794 (N.D. Tex. 2001).

defend and to indemnify the underlying lawsuit.¹²³

The policy in question provided coverage for a covered "event," which was defined to be "an accident, including continuous or repeated exposure to substantially the same general harmful conditions."¹²⁴ The insured argued that "Trinity's allegation that [it] negligently diverted the waters of the creek relied upon an underlying legal theory of negligence, thus triggering [the insurer's] duty to defend." The court rejected this argument, noting that it is the facts giving rise to the alleged actionable conduct rather than the cause of action alleged that determines coverage. The court found that the insured purposefully impounded the creek to screen and dredge construction materials. Thus, despite the allegations, "the acts ultimately leading to the underlying lawsuit were intentional, not negligent."¹²⁵

The insured further argued that the injury to Trinity triggered coverage because the insured never intended to injure Trinity. In addressing this argument, the court noted that the Texas Supreme Court has instructed courts to look at "both the actor's intent and the reasonably foreseeable effect of his conduct."¹²⁶ Under this test, the court noted that "an injury is accidental if from the viewpoint of the insured, [it is] not the natural and probable consequence of the action or occurrence which produced the injury; or in other words, if the injury could not reasonably be anticipated by the insured, or would not ordinarily follow from the action or occurrence which caused the injury."¹²⁷ The court further noted that "the law does not require foresight of specific details before a court may find that these injuries were not accidental."¹²⁸ Rather, the court held that public policy compelled a finding that the existing water permit system provided sufficient notice to upstream users that "their actions have natural and probable downstream impacts."¹²⁹

Applying these principles, the court held that the incident prompting the lawsuit was the insured's intentional act in diverting water. Since the injuries naturally and foreseeably resulted from the insured's diversion of the creek, the court concluded that the damages did not constitute a covered "event" and, therefore, the insurer had no duty to defend.

2. *Insured's Recovery of Money Withheld Under Contract*

Acceptance v. S&S: Insured Is Entitled to Recover from Insurer Money Withheld By Third Party Under a Contract to Compensate Third Party for the Insured's Negligence

123. *Id.* at 796.

124. *Id.* at 797.

125. *Id.*

126. *Id.* (citation omitted).

127. *Martin Marietta*, 145 F. Supp. 2d at 798.

128. *Id.* at 799.

129. *Id.*

In *Acceptance Ins. Co. v. S&S Telecom, Inc.*,¹³⁰ the 285th Judicial District Court of Bexar County addressed whether an insured's negligence in damaging phone equipment which resulted in the insured receiving an offset of payment constituted an "occurrence," thereby triggering coverage. In this case, the insured entered into several service contracts with Southwestern Bell ("SWB") to remove telephone equipment from SWB's facility. The insured's employees damaged SWB's equipment during the removal, and SWB demanded that the insured pay \$66,004 to repair the damaged equipment. The insured filed a claim with its insurer seeking coverage for the loss, and the insurer denied coverage. After the insured failed to pay SWB for the damaged equipment, SWB withheld \$66,004 from its payment to the insured under the service contracts. The insured filed suit against SWB for breach of the service contract by withholding payments, and the trial court held that SWB did not breach the contract, because the insured negligently damaged SWB's equipment.¹³¹

The insured then sued its insurer alleging that it breached the policy by denying the claim. The insured sought to recover the amount withheld by SWB, plus attorney's fees expended in pursuing its breach of contract claim against SWB and attorney's fees expended in the coverage action. The trial court granted summary judgment in favor of the insured.

At trial and on appeal, the insurer argued that there was no coverage because SWB's withholding of repair costs did not constitute an "occurrence." In addressing this point, the court of appeals looked to the facts underlying the insured's alleged liability. In particular, the court evaluated the insured's actions leading to SWB's injury, rather than SWB's reaction to the injury. The court found that the insured negligently damaged SWB's equipment, thereby causing damage to SWB in the amount of \$66,004. Accordingly, since the insured's liability arose from its negligence, the court held that the policy provided coverage for the loss.¹³²

The insurer also challenged the insured's award of attorney's fees in both the underlying and coverage actions. In addressing the recovery of attorneys' fees in the underlying action, the court of appeals noted that if the converse of this case had occurred, that is, if SWB had sued the insured, then the insured would be able to collect attorney's fees incurred in defending itself in the underlying lawsuit because the duty to defend would have been triggered. The court noted, however, that this case could be distinguished because the insured was not forced to defend itself in a suit brought by SWB. Instead, the insured "took affirmative action to sue SWB for withholding payment." The court noted that there was no provision in the insurance contract providing coverage for legal fees incurred when the insured chooses to sue third parties. Accordingly, the court overruled the award of attorney's fees in the underlying action. On

130. No. 04-00-00634-CV, 2001 WL 844749 (Tex. App.—San Antonio 2001, July 25, 2001).

131. *Id.* at *1.

132. *Id.* at *2.

the other hand, the court of appeals affirmed the trial court's award of attorney's fees incurred in the coverage action finding that the insurer had breached the contract and, therefore, the insured was entitled to recover fees incurred in pursuing the coverage action under Section 38.001 of the Texas Civil Practice and Remedies Code.¹³³

3. *Fortuity Doctrine*

Scottsdale v. Travis: Lack of Fortuity Negates Duty to Defend

Scottsdale Insurance Company v. Travis,¹³⁴ illustrates the application of the fortuity doctrine to negate coverage. In this case, the insured, Richard Robinson, resigned from his position as manager of Maintenance Houston in 1993 and set up a competing janitorial business called South Texas. The insured's former employer then sued Robinson and South Texas alleging that Robinson recruited its employees and customers, made false accusations and began spreading ill-will among its customers, and used his knowledge of its customer lists and secrets to steal business for his new company. In its petition, Maintenance alleged causes of action against the insureds for misappropriation of trade secrets, tortious interference with contracts, breach of fiduciary duty, and conversion, all arising from the insured's conduct in leaving Maintenance and starting South Texas.

The insureds demanded a defense in the underlying lawsuit from their insurer, Scottsdale Insurance Company, pursuant to their primary and excess insurance policies, which became effective on August 9, 1993. Scottsdale filed a declaratory judgment action asserting that it did not owe a duty to defend, and the insureds counterclaimed. On cross-motions for summary judgment, the district court found that Scottsdale owed a duty to defend. Therefore, "[t]he trial court entered judgment ordering Scottsdale to tender a defense and awarding [the insureds'] attorney's fees incurred in the underlying litigation as well as the coverage action."¹³⁵

On appeal, Scottsdale argued that there was no duty to defend because the alleged offenses occurred prior to "the inception of the coverage and [were], therefore, excluded as a matter of law by both the policy and the fortuity doctrine."¹³⁶ In support of its argument, Scottsdale pointed "to a provision in the policy providing that coverage was triggered only if the offense was committed during the policy period." Additionally, Scottsdale argued that the fortuity doctrine precluded coverage for offenses because they were committed before the policy period. The fortuity doctrine precludes coverage for both a "known loss" or a "loss in progress." "A 'known loss' is a loss the insured knew had occurred prior to

133. *Id.* at *2-3.

134. No. 05-99-01831-CV, 2001 WL 569300 (Tex. App.—Dallas May 29, 2001, rehearing denied).

135. *Id.* at *1.

136. *Id.* at *2.

making the insurance contract.”¹³⁷ “A ‘loss in progress’ occurs when the insured is, or should be, aware of an ongoing progressive loss at the time the policy is purchased.”¹³⁸ The insured, however, attempted to argue that the fortuity doctrine did not apply because “no liability had been established and no actual loss had occurred before the inception of the policy.”¹³⁹ Specifically, the insured contended that even though the allegations pertained to his conduct before the inception of the policy and before he formed a competing business, he did not use the information until after South Texas was formed and the policy was in effect. He contended that Maintenance was not injured until he used the information and, therefore, Maintenance’s cause of action did not accrue until after the policy incepted.

The Dallas Court of Appeals was not persuaded by the insured’s arguments. Rather, the court noted that the key question was “whether the wrongdoing occurred before or after the purchase of the insurance.”¹⁴⁰ The court stated that the fortuity doctrine “has its roots in the prevention of fraud; because insurance policies are designed to insure against fortuities, fraud occurs when a policy is misused to insure a certainty.”¹⁴¹ The court applied the eight corners rule and determined that the pleadings alleged a loss in progress. Specifically, the court noted that all of the allegations pertained to the insured’s conduct before the inception of the insurance policy, and even before South Texas was formed as a corporation. The court concluded that the purpose behind the fortuity doctrine applied to this case, because the insured attempted to purchase insurance against the consequences of his own ongoing wrongful conduct. Thus, since the petition alleged that the wrongdoing began before the policy was purchased, the court held that coverage was excluded under both the specific terms of the insurance policy and the fortuity doctrine as a “loss in progress.” As a result, the court reversed the trial court’s judgment and rendered judgment that Scottsdale had no duty to defend.¹⁴²

B. HOMEOWNER’S POLICIES

1. Concurrent Causes Doctrine

State Farm v. Kaip: Where Covered and Non-covered Perils Combine to Create a Loss, Insured is Entitled to Recover Only Portion of Damages Which the Insured Establishes Are Caused by the Covered Peril

137. *Id.* (citing *Burch v. Commonwealth Mut. Ins. Co.*, 450 S.W.2d 838, 840-41 (Tex. 1970)).

138. *Travis*, 2001 WL 569300, at *2 (citing *Two Pesos, Inc. v. Gulf Ins. Co.*, 901 S.W.2d 495, 502 (Tex. App.—Houston [14th Dist.] 1995, no writ)).

139. *Id.* at *4.

140. *Id.*

141. *Id.* at *2 (citing *Inland Waters Pollution Control, Inc. v. Nat’l Union Fire Ins. Co.*, 997 F.2d 173, 175-77 (6th Cir. 1993)).

142. *Id.* at *5.

In *State Farm Lloyds v. Kaip*,¹⁴³ the Dallas Court of Appeals addressed the difficult burden a plaintiff must overcome in concurrent causation cases. Sharon Kaip, the insured, sustained damage to her roof following a hailstorm. Kaip made a claim under her homeowners' policy, and her insurer, State Farm, sent several adjusters to inspect the roof. The adjusters concluded that only one shingle was damaged by hail, and the rest of the damage on the roof was due to deterioration that was not covered by the policy. As a result, State Farm offered to pay Kaip for only the one shingle that contained possible hail damage minus her deductible. Kaip eventually "had her roof replaced at her own cost, and sued State Farm for breach of its homeowner's policy, breach of the duty of good faith and fair dealing, and violations of the Insurance Code and the Texas Deceptive Trade Practices Act."¹⁴⁴

At trial, State Farm's expert testified that the damage was not caused by hail but was caused by an inherent defect in the type of shingle used and ordinary wear and tear and deterioration. Kaip's expert acknowledged that there were other causes of the damage to the roof, including defects in the shingles, the way the shingles were laid out, normal deterioration, and normal wear and tear; however, he testified that the catalyst of the deterioration was the hail. Kaip's expert further admitted that it would be difficult to quantify the causes. The jury found that Kaip's roof was damaged because of a loss under the Policy and that State Farm breached its duty of good faith and fair dealing. Therefore, the trial court entered judgment against State Farm.¹⁴⁵

On appeal, State Farm argued that the evidence at trial established that Kaip's roof had to be replaced because of a combination of causes, some excluded and some covered. Thus, State Farm argued that Kaip failed to meet her burden of proof under the doctrine of concurrent causes by establishing which portion of her claim was covered. In addressing this issue, the court of appeals concluded that the admission by Kaip's expert that hail, wear and tear, deterioration, inherent defect, rain, and the way the shingles were laid all contributed to the damage to the roof raised the issue of concurrent causation. The court noted that "under the doctrine of concurrent causes, where covered and non-covered perils combine to create the loss, the insured is entitled to recover only that portion of the damage caused solely by the covered peril."¹⁴⁶ The court found that Kaip failed to meet her burden of proof because Kaip did not attempt to determine the amount of loss caused by the hail and to secure a jury finding on the amount of damage attributable to hail. Accordingly the court of appeals held that there was no evidence to support the jury's finding that Kaip's entire roof had to be replaced because of a loss under the Policy.

143. No. 05-99-01363-CV, 2001 WL 670497 (Tex. App.—Dallas June 15, 2001, pet. denied).

144. *Id.* at *1.

145. *Id.* at *2.

146. *Id.* at *2 (citing *Travelers Indemnity Co. v. McKillip*, 469 S.W.2d 160, 162 (Tex. 1971)) (other citations omitted).

The court also held that State Farm's liability on the contract never became reasonably clear because a bona fide dispute existed as to the cause of the damage to Kaip's roof. Therefore, the court held that State Farm was not liable for common law or statutory bad faith.¹⁴⁷

2. "Ensuing Loss"

Harrison v. U.S.A.A.: Loss Caused by Rotting Resulting from Water Damage Does Not Constitute Ensuing Loss and is Therefore Excluded by Exclusion (f) of Homeowners' Policy

In *Harrison v. U.S.A.A. Insurance Co.*,¹⁴⁸ the Austin Court of Appeals addressed whether the "ensuing loss" provision of a homeowners' policy provided coverage for rot caused by water damage. This case arose after a homeowner noticed that the caulking between her bathtub and the tile had deteriorated, allowing water from the shower to seep through the caulking to the surrounding wooden structure, and causing it to rot. The homeowner replaced the sheetrock, floor joists, and beams that had rotted, as well as wall tile and flooring in the bathroom that was supported by rotted wood, and sought coverage from USAA under her homeowner's insurance policy. USAA denied the claim on the grounds that the loss was caused by rot and was, therefore, excluded by exclusion (f).¹⁴⁹ As a result, the homeowner filed suit alleging breach of contract, breach of good faith and fair dealing, and violations of the Insurance Code. USAA moved for summary judgment, and the trial court granted summary judgment without stating its grounds.

On appeal, the homeowner challenged the summary judgment on her breach of contract claim arguing that the trial court misinterpreted the legal effect of two provisions in the policy: (1) the ensuing loss provision, and (2) the exclusion repeal provision. First, the homeowner argued that the ensuing loss provision provided coverage for her property damage. The court rejected the homeowners' argument noting that the argument reverses the causation required by that exception. The court stated that:

[t]o qualify for the exception, ensuing water damage must follow from one of the types of damage enumerated in exclusion (f). In other words, the ensuing loss provision covers water damage that results from, rather than causes, rotting. Applying this principle to the facts, the Court noted that the event causing the loss was the rotting of the wood surrounding the bathtub. The Court further noted that, assuming that the leaking water into the wood constituted water damage, the leaking preceded, rather than followed, the [home-

147. *Id.* at *5.

148. No. 03-00-00362-CV, 2001 WL 391539 (Tex. App.—Austin April 19, 2001).

149. *Id.* at *2. Exclusion (f) excluded coverage for loss caused by: (1) wear and tear, deterioration or loss caused by any quality in property that causes it to damage or destroy itself, and (2) rust, rot, mold or other fungi. However, the policy expressly reinstates coverage for "ensuing loss" caused by water damage if the loss would otherwise be covered by the policy.

owner's] loss.¹⁵⁰

Therefore, the court held that the ensuing loss provision did not extend coverage.¹⁵¹

In her second point, the homeowner argued that the exclusion repeal provision overrides exclusion (f).¹⁵² Specifically, the homeowner attempted to argue that the loss resulted from a leak in a plumbing system and, therefore, the exclusion did not apply. In addressing this argument, the court noted that the term "plumbing system" was not defined in the policy so it must be given its ordinary and generally accepted meaning. The court then stated that when Texas courts consider plumbing claims under clauses similar to the instant provision, these claims almost exclusively involve water escaping from pipes located within the unseen internal structure of the home. Thus, the court concluded that leaking of water through the caulking was not an accidental discharge of water from within the plumbing system. Accordingly, the court affirmed the trial court's summary judgment in favor of the insurer.¹⁵³

Harrison follows the line of Texas cases holding that the ensuing loss provision of homeowners' policies covers water damage that results from, rather than causes, one of the types of damage enumerated in exclusion (f), such as rust, rot, mold or fungi. While this appears to be the majority view adopted by Texas Appellate Courts, at least one Texas Appellate Court has reversed the causation. In *Home Insurance Co. v. McClain*,¹⁵⁴ the Dallas Court of Appeals adopted a similar argument to the one made by the homeowner in *Harrison*. In *McClain*, the Dallas Court of Appeals held that to be an ensuing loss caused by water damage, the mold and fungi would necessarily have to follow the water damage. Finding that the mold and fungi resulted from water damage, the *McClain* Court held that the loss constituted an ensuing loss and was covered. Given the conflicting interpretations of the ensuing loss provision by Texas Appellate Courts and the increase in black mold cases in Texas which will inevitably turn on this provision, it appears that this issue is ripe for the Texas Supreme Court.

3. *Declaratory Judgment Against Insured Was Binding on Third Party Claimant*

Balog v. State Farm: Insurer's Declaratory Judgment of No Duty to Indemnify Held to Be Binding on Injured Third Party

150. *Id.* at *2 (citing *Lambros v. Standard Fire Ins. Co.*, 530 S.W.2d 138, 139-40 (Tex. Civ. App.—San Antonio 1975, writ ref'd)).

151. *Id.*

152. *Id.* at *2-3. The exclusion repeal provides that exclusions 1.a through 1.h do not apply to loss caused by accidental discharge, leakage or overflow of water or steam from within a plumbing, heating or air conditioning system or household appliance.

153. *Harrison*, 2001 WL 391539, at *3.

154. No. 05-97-01479-CV, 2000 Tex. App. WL 144115 (Tex. App.—Dallas Feb. 10, 2000).

In *Balog v. State Farm Lloyds*,¹⁵⁵ Kay Balog filed a civil action against the insured after the insured attacked her during a robbery. The insured requested State Farm, its homeowner's carrier, to provide a defense, and State Farm filed a declaratory judgment action. State Farm received a declaratory judgment that it had no duty to defend because the policy excluded intentional conduct from coverage. Balog eventually obtained a judgment against the insured for \$2.72 million. Balog then sued State Farm seeking "to recover that portion of the judgment within the policy limits (\$300,000), as well as the amount awarded by the jury in excess of the policy limits."¹⁵⁶ State Farm filed a third-party declaratory judgment action against the insured seeking a determination that it had no duty to indemnify the insured for the underlying judgment. State Farm did not assert a claim for declaratory relief against Balog. The insured did not answer, and the trial court entered a default declaratory judgment in favor of State Farm. State Farm moved for summary judgment against Balog, and the trial court granted the motion for summary judgment.¹⁵⁷

A key issue on appeal was whether the declaratory judgment that State Farm had no duty to indemnify was binding on Balog. In its motion for summary judgment and on appeal, State Farm argued that Balog could not recover as a judgment creditor because State Farm had received a declaratory judgment that it had no duty to indemnify in the same action. In addressing this issue, the El Paso Court of Appeals noted that the insured is a third party beneficiary of a liability insurance policy.¹⁵⁸ However, the court noted that the injured party may only proceed against the insurer "once it has been established by judgment or agreement that the insured has a legal obligation to pay damages to the injured party."¹⁵⁹ The court also looked to the Texas Supreme Court's decision in *Dairyland County Mutual Insurance Co. of Texas v. Childress*.¹⁶⁰ In *Dairyland*, the Texas Supreme Court held "that the insured and the injured party are not in privity with regard to a declaratory judgment action brought by the insurer to determine coverage rights prior to the adjudication of the underlying claim by the injured party against the insured."¹⁶¹ Rather, the injured party, "as a third-party beneficiary of the liability insurance contract, has rights which may not be precluded by the prior action solely between the insured and the insurer."¹⁶² The court of appeals noted that "pursuant to *Dairyland*, the first declaratory judgment regarding the duty to defend would not be binding on Balog since she was not a party to that

155. No. 08-00-00324-CV, 2001 WL 997412 (Tex. App.—El Paso Aug. 30, 2001).

156. *Id.* at *1.

157. *Id.* at *1.

158. *Id.* at *3 (citing *State Farm County Mut. Ins. Co. of Texas v. Ollis*, 768 S.W.2d 722, 723 (Tex. 1989)).

159. *Id.*

160. *Id.* (citing *Dairyland County Mut. Ins. Co. of Texas v. Childress*, 650 S.W.2d 770 (Tex. 1983)).

161. Balog, 2001 WL 997412, at *3.

162. *Id.*

action.”¹⁶³

In distinguishing this case from *Dairyland*, the court of appeals noted that State Farm filed its second declaratory petition for declaratory judgment related to the indemnification issue after Balog had obtained a judgment against the insured. The court further noted that the declaratory judgment action was filed in the instant case, and State Farm served Balog’s counsel with a copy of the petition. Consequently, the court held that *Dairyland* was inapplicable to the second declaratory judgment. Thus, the court of appeals held that the trial court’s determination that State Farm had no duty to indemnify the insured was binding on Balog since it was made in the same proceeding. Accordingly, the court affirmed the trial court’s judgment.¹⁶⁴

4. *Use of Extrinsic Evidence in Determining Duty to Defend*

National General v. Hunter: Court Considers Extrinsic Evidence in Determining Duty to Defend Under Homeowner’s Policy

When determining whether an insurer has a duty to defend a lawsuit against the insured, Texas law applies the “eight corners test.”¹⁶⁵ Under this test, “the allegations made in the underlying complaint are compared with the terms of the insurance policy, and if any allegations fall within its coverage, a duty to defend arises.”¹⁶⁶ The duty to defend is unaffected by facts ascertained before suit, developed in trial, or by the ultimate outcome of the case.¹⁶⁷ The duty to defend is broader than the duty to indemnify. Thus, “if an insurer has no duty to defend a specific lawsuit, it likewise bears no duty to indemnify the insured against any resulting adverse judgment.”¹⁶⁸

*National General Ins. Co. v. Hunter*¹⁶⁹ provides an example of a situation where a Texas federal court looked to extrinsic evidence in determining the existence of a duty to defend. The insureds in that case owned two separate residences—a dwelling at 7221 Montgomery Road in Midlothian, Texas (the “Montgomery Residence”) and a home at 9823 Marlin Street in Dallas, Texas (the “Rental Property”). The insureds resided at the Montgomery Residence and rented the Rental Property to a tenant. The insureds’ homeowners’ policy, issued by National General, provided coverage for the Montgomery Residence only. In 1998, the tenant in the insured’s Rental Property died, and the tenant’s son sued the insureds

163. *Id.*

164. *Id.*

165. *See, e.g., Martin Marietta Southwest, Ltd. v. St. Paul Guardian Ins. Co.*, 145 F. Supp. 2d 794, 796 (N.D. Tex. 2001) (citing *National Union Fire Ins. Co. v. Merchants Fast Motor Lines, Inc.*, 939 S.W.2d 139, 141 (Tex. 1997)).

166. *Id.*

167. *Malone v. Scottsdale Ins. Co.*, 147 F. Supp. 2d 623, 627 (S.D. Tex. 2001) (citations omitted).

168. *Martin Marietta Southwest, Ltd.*, 145 F. Supp. 2d at 797 (citing *Western Heritage Ins. Co. v. River Entertainment*, 998 F.2d 311, 315 (5th Cir. 1993)).

169. No. CIV.A.3:00-CV-2604G, 2001 WL 803728 (N.D. Tex. July 13, 2001).

alleging that his mother died due to heat and lack of electricity in the Rental Property and that the insureds' negligence proximately caused his mother's death. In his pleading, the tenant's son alleged that his mother was a tenant in a home owned by the insureds at the time of her death; however, the petition did not specify the address of the property. Because the petition did not designate an address, National General defended the insureds under a reservation of rights.¹⁷⁰

National General filed a declaratory judgment action seeking a declaration that it had no duty to defend or indemnify the insureds. In evaluating whether National General had a duty to defend and indemnify, the court first looked to the terms of the Homeowners' policy. The court noted that the policy specifically did not apply to "bodily injury . . . arising out of a premises . . . rented to others by an insured . . . that is not an insured location."¹⁷¹ The policy further defined an "insured location" as the "residence premises."¹⁷² In determining whether the allegations triggered coverage, it appears that the court considered extrinsic evidence outside the "eight corners" of the policy and the petition. The court found that the tenant died on the premises of the Rental Property and that the insureds did not reside in the Rental Property at the time of the tenant's death. Thus, the court held that the Rental Property was not an "insured location" under the terms of the Policy, and National General had no duty to defend or indemnify the insureds in the underlying litigation.¹⁷³ This decision is consistent with the reasoning in prior cases that have looked to extrinsic evidence to determine whether a defendant qualifies as an insured under a policy.

C. LIFE AND HEALTH POLICIES

Rodriguez v. Unum: Driving While Intoxicated Constitutes Commission of Crime ; Therefore, Life Insurance Policy Does Not Provide Coverage for Fatal Accident Caused When Insured Was Driving While Intoxicated

In *Rodriguez v. Unum Life Ins. Co.*,¹⁷⁴ a Texas federal court addressed whether an insured's automobile accident was covered by a life insurance policy when the accident occurred when the insured was intoxicated. In this case, the insured was killed in a traffic accident when his car crossed the double center yellow line and collided with a second vehicle. The decedent's blood alcohol content at the time of the accident was 0.17%. The insured's wife filed a claim to recover under the insured's life and accidental death and dismemberment benefits, and the insurer, Unum Life Insurance Company, denied coverage on the ground that the decedent's death resulted from or was contributed to by the commission of a

170. *Id.* at *1.

171. *Id.* at *3.

172. *Id.*

173. *Id.*

174. No. 41-00-CV-1805-A, 2001 WL 881287 (N.D. Tex. July 26, 2001).

crime. The policy specifically excluded accidental losses caused by, contributed to by, or resulting from “an attempt to commit or commission of a crime under state or federal law.”¹⁷⁵ The insured’s wife sued Unum alleging that it acted in bad faith in denying her claim, and Unum moved for summary judgment.

The court found that the evidence was sufficient to support summary judgment. Specifically, the evidence established “that at the time of his death, the insured was intoxicated, having an alcohol concentration of more than 0.10%.”¹⁷⁶ Furthermore, the court found that the insured violated the Texas Penal Code by operating his vehicle while intoxicated and causing bodily injury to the other driver. Accordingly, because the insured’s death resulted from or was contributed to by the commission of a crime, the court held that the claim was excluded under the Policy.¹⁷⁷ Although this outcome seems harsh, it appears to be a technically accurate application of the exclusion to the factual situation presented.

D. AUTOMOBILE POLICIES

1. *Temporary Substitute Vehicle Exception*

Sink v. Progressive: Although Policy Excluded Coverage for Person Using Vehicle Without Permission, Exception to Exclusion Allowed Coverage for Driver Using Vehicle Without Permission as a Temporary Substitute

Sink v. Progressive County Mutual Ins. Co.,¹⁷⁸ involved the construction of the following exclusion in an automobile liability policy: “We do not provide *Liability Coverage* for any person:

8. Using a vehicle without a reasonable belief that that person is entitled to do so.

This exclusion (8.) does not apply to you or any family member while using your covered auto.”¹⁷⁹ The policy also defined the term “[y]our covered auto” to mean “[a]ny auto or trailer you do not own while used as a temporary substitute for any other vehicle described in this definition which is out of normal use because of its breakdown, repair, servicing, loss, or destruction.”¹⁸⁰

The insured, Joshua McCauley, purchased an automobile policy covering his pickup truck from Progressive County Mutual Insurance Company. The insured’s pickup truck became disabled, and the insured borrowed his employer’s car without permission to pick up tools so he could work on his truck. When the insured was returning to work in his employer’s car, he was involved in an accident with Paul Sink. Sink sued the insured and was ultimately awarded damages in the underlying law-

175. *Id.* at *1.

176. *Id.* at *3.

177. *Id.* at *2.

178. 47 S.W.3d 715 (Tex. App.—Texarkana 2001, no pet.).

179. *Id.* at 716-17.

180. *Id.* at 717.

suit. After Sink filed the underlying litigation, Progressive filed a declaratory judgment action seeking a declaration that it was not required to provide coverage to the insured. Progressive based its argument on a policy exclusion that excluded liability coverage for any person using a vehicle without a reasonable belief that he had the right to do so.¹⁸¹ Progressive received a favorable judgment holding that it had no obligation to the insured.¹⁸²

The insured then filed for bankruptcy and received a discharge of the obligation owed to Sink. Sink obtained the right of action against the insurer from the bankruptcy court and sued Progressive. Sink sought to recover from Progressive the policy limits, "as well as the total amount of the judgment rendered against [the insured] under a *Stowers* cause of action, breach of duty to settle," and violation of the Insurance Code.¹⁸³ The trial court found that Sink was not entitled to pursue any extra-contractual actions against Progressive, because the bankruptcy court had held that Sink could not pursue such actions. Since Sink had appealed the ruling as to the extra-contractual claims, the trial court severed the contractual claims from the extra-contractual claims. The trial court determined that the sole issue in the contract claim was to be determined as a matter of law and ordered that Sink take nothing on his contract claim.¹⁸⁴

On appeal, Sink argued that coverage existed because the facts fell within an exception to the exclusion, which provided that the exclusion did not apply to the insured while driving a covered automobile, defined as including a temporary substitute vehicle. The issue before the court was whether the fact that the insured was using a vehicle without the permission of its owner automatically excluded liability coverage, even if the vehicle was being used as a temporary substitute vehicle. The Texas Court of Appeals found that at the time of the accident the insured "was driving a temporary substitute vehicle because his own vehicle had become disabled."¹⁸⁵ The court held that "the unambiguous language of the policy indicated that in such a situation, the entitlement exclusion did not apply."¹⁸⁶ Accordingly, the court of appeals reversed the trial court's ruling.¹⁸⁷

2. *Unauthorized Driver*

Eilander v. Federated: Driver Who Received Permission to Operate Company-Owned Vehicle from Employee Who Lacked Authority to Grant Such Permission Was Not Insured Under Company's Policies and, There-

181. *Id.* at 716.

182. *Id.* at 721.

183. *Sink*, 47 S.W.3d at 721.

184. *Id.*

185. *Id.* at 721.

186. *Id.*

187. *Id.*

fore, Was Not Entitled to Defense in Litigation Arising from Automobile Accident

In *Eilander v. Federated Mutual Ins. Co.*,¹⁸⁸ a Texas federal court addressed the scope of the permissive user provision under a commercial automobile policy and excess policy. In this case, David Eilander was killed when the vehicle in which he was a passenger was involved in a one-car accident. At the time of the accident, Eilander had allegedly given permission to Tina Walker to drive his company-owned vehicle. Walker was drunk at the time of the accident, and both Walker and Eilander were killed. Eilander's parents filed a wrongful death action against Walker in state court. The Eilanders claimed that their son had given Walker permission to drive his company-owned vehicle and, therefore, Walker was an insured under the company's commercial automobile and excess policies. The insurer denied coverage on the grounds that Walker was not an insured. The Eilanders obtained a \$6 million judgment against Walker. After an assignment of benefits and claims, the Eilanders sued the insurer to collect the judgment, and the insurer moved for summary judgment on the ground that Walker was not an insured under the applicable policies.¹⁸⁹

The key issue was whether Walker was an insured driver under the company policies. The Eilanders alleged that their son, as a manager, had authority to authorize Walker to drive the company vehicle and, therefore, Walker was a covered permissive user. The court, however, rejected this argument finding that only a named insured was authorized to make a permissive user of a covered vehicle an additional insured under the policies. The court found that Eilander was not authorized to permit a non-employee to drive a company vehicle. Specifically, the summary judgment evidence established that Eilander had been advised on two separate occasions about the company's policy of not allowing non-employees to drive the pickup. Accordingly, the court held that the insurer had no duty to defend or indemnify, because Walker was not a permissive user under the policies.¹⁹⁰

3. "Occupying" Vehicle

Old American County v. Sanchez: Insured Is Not Deemed to be "Occupying" Vehicle When Lying Underneath Car to Conduct Repairs

In *Old American County Mutual Fire Insurance Co. v. Sanchez*,¹⁹¹ the Austin Court of Appeals addressed two issues: (1) whether an insured is deemed to be occupying a vehicle when he is underneath the vehicle performing repairs, and (2) whether a spouse who is the applicant for an

188. No. 4:00-CV-1746-A, 2001 WL 770986 (N.D. Tex. July 3, 2001, no pet.).

189. *Id.* at *1.

190. *Id.* at *3-4.

191. No. 03-01-00150-CV, 2001 WL 1422581 (Tex. App.—Austin Nov. 15, 2001, no pet.).

automobile insurance policy, but not the “named insured,” can waive PIP and UM coverage for the insured. The insured, Mr. Sanchez, “was injured when an uninsured motorist struck a truck owned by [him] but not listed as a covered vehicle on his automobile insurance policy.”¹⁹² At the time of the accident, Sanchez was working on the gas tank hose underneath the truck when the accident occurred. Sanchez sought to recover uninsured/underinsured motorist coverage and personal injury protection from his insurer. The insurer filed a declaratory judgment action seeking a declaration that it was not obligated to pay for Sanchez’s injuries, and Sanchez counterclaimed.

The trial court granted summary judgment in favor of the insurer on the ground that Sanchez’s claim was barred by the owned-vehicle exclusion because he was occupying an uninsured truck at the time of the accident. The insurer argued that Sanchez was “occupying” an uninsured vehicle at the time of the accident and, therefore, was not covered. On the other hand, Sanchez argued that he was not struck by his vehicle for purposes of the insurance exception, because his vehicle was not the striking force responsible for the accident. The trial court found that Sanchez was “occupying” the vehicle and granted summary judgment in favor of the insurer.¹⁹³

The court of appeals noted that the policy defined “occupying” as “in, upon, getting in, on, out or off.”¹⁹⁴ Based on the facts, the Court determined that Sanchez’s claim would be barred unless he was found to be “upon” the vehicle. Although the term “upon” was not defined in the policy, the court of appeals noted that under Texas law, the term suggests that one needs to be supported by an object to be deemed “upon” the object. The court declined to broaden the term “upon” to include “touching a vehicle from underneath while resting on the ground beneath the vehicle.”¹⁹⁵ Therefore, because Sanchez was not “upon” the vehicle, the court sustained Sanchez’s appeal on this issue.¹⁹⁶ However, as discussed in the following section, the court found that Sanchez’s claim was barred because the PIP and UIM benefits had been waived.

4. Waiver of PIP and UIM Benefits

Old American County v. Sanchez: Spouse May Waive PIP and UIM Coverage for Insured

In *Sanchez*, as an additional ground for summary judgment, the insurer argued that the policy waived coverage for PIP and UIM benefits and charges were never assessed for these items. Sanchez did not dispute that the policy waived PIP and UM coverage. Instead, Sanchez argued that

192. *Id.* at *1.

193. *Id.*

194. *Id.* at *2.

195. *Id.* at *4.

196. *Old Am. County*, 2001 WL 1422581, at *5.

the waiver was not effective because his wife had purchased and signed the policy instead of him, and his wife was not the named insured. Thus, Sanchez argued that his wife was not authorized to waive such coverage. The trial court did not rule on this ground.¹⁹⁷

On appeal, Sanchez challenged the summary judgment on the other issue, and the insurer cross-appealed arguing that summary judgment should have been granted on the issue of waiver. In addressing whether Sanchez's spouse's rejection of PIP and UM was valid, the court noted that "[g]enerally for the purpose of insurance policies, the spouse of the named insured is treated the same as the named insured."¹⁹⁸ The court also noted that "[t]he definitions in Sanchez's policy specifically stated that 'you' and 'your' in the policy referred to both the named insured and the spouse of the named insured."¹⁹⁹ Thus, the court concluded that the Sanchezes were treated the same under the policy and had the same rights to waive PIP and UM coverage. The court further found that to allow the Sanchezes to recover PIP and UM benefits without paying for the coverage and after waiving such benefits would contravene the legislature's intent to allow written waivers of PIP and UM.²⁰⁰ Moreover, the court held that it was clear from the application that Sanchez's spouse intended to take out a policy in both their names, and the fact that the insurance company entered Sanchez as the only "named insured" should not invalidate the waiver.²⁰¹ Accordingly, the court held that the waiver by Sanchez's spouse was valid.

5. Estoppel

Forsyth v. Allstate: Insurer Estopped from Claiming Insured's Dismissal of Third-Party Claim With Prejudice, Pursuant to Settlement Agreement, Barred UIM Claim Where Insurer Consented to Settlement

In *Forsyth v. Allstate Ins. Co.*,²⁰² the Beaumont Court of Appeals considered whether an insured's release of claims against an underinsured motorist with prejudice precluded the insured from recovering under his own underinsured motorist coverage. In this case, the insured was involved in a collision with an underinsured motorist, and the insured and his wife sued the underinsured motorist. The insured eventually decided to release his claims in exchange for the other driver's liability policy limits. Before signing the release, the insured sought permission from his insurance carrier, Allstate Insurance Company, because he did not want to be barred from pursuing an underinsured motorist claim under the policy. The insured's policy "required him to prove that he was legally 'entitled to recover' from the driver of an underinsured motor vehi-

197. *Id.*

198. *Id.* at *6.

199. *Id.*

200. *Id.*

201. *Old Am. County*, 2001 WL 1422581, at *6.

202. No. 09-00-227-CV, 2001 WL 726319 (Tex. App.—Beaumont April 26, 2001).

cle.”²⁰³ Thus, “[the insured] was concerned that releasing the other driver from liability without Allstate’s approval might bar his UIM claim on the grounds that he was no longer ‘legally entitled to recover’ against [the other driver].”²⁰⁴ Allstate consented to the insured’s settlement, and the insured released his suit against the other driver with prejudice.

The insured then sued Allstate for UIM benefits. Despite the fact that Allstate gave the insured permission to settle the third-party claim, Allstate sought and received summary judgment on the grounds that the insured had dismissed his third-party lawsuit “with prejudice” and, therefore, he was no longer legally entitled to recover from the other driver. The insured appealed on the ground that Allstate gave him permission to settle and was, therefore, estopped from asserting the contractual provision.²⁰⁵ In reaching its decision, the Beaumont Court of Appeals noted that Allstate argued that the insured’s claim “was barred only because of the method of dismissal of the lawsuit—with, rather than without, prejudice.”²⁰⁶ The court further noted that Allstate’s settlement authorization letter did not warn the insured that the method of dismissal had any significance. Rather, Allstate clearly advised the insured, without reservation, that it was waiving subrogation rights and that the insured could settle “without hampering any rights to a possible future UIM Claim.”²⁰⁷ Since the insured relied on Allstate’s promise, the court held that Allstate was estopped from claiming that the insured’s settlement of the third-party claim barred the UIM claim. Accordingly, the court reversed the summary judgment and remanded the case.²⁰⁸

6. Coverage for Injury While Exiting Vehicle

Texas Farm Bureau v. Sturrock: Insured’s Injury Occurring When His Foot Became Entangled While Exiting Vehicle Is Deemed “Motor Vehicle Accident” Within Policy

In *Texas Farm Bureau Mutual Insurance Co. v. Sturrock*²⁰⁹ the Beaumont Court of Appeals addressed whether an injury that occurred when the insured’s foot became entangled while exiting a vehicle was a “motor vehicle accident” under the insured’s automobile policy. In this case, the insured made a claim for personal injury protection benefits for an injury incurred as he exited his pickup truck. The insurer denied the claim, and the insured filed suit against his insurer alleging breach of contract and bad faith. The trial court held that the insured’s injuries resulted from a “motor vehicle accident” under the policy. The trial court severed the

203. *Id.* at *1 (internal citations omitted).

204. *Id.*

205. *Id.*

206. *Forsyth*, 2001 WL 726319, at *1.

207. *Id.*

208. *Id.* at *4.

209. No. 09-01-089-CV, 2001 WL 1549270, at *1 (Tex. App.—Beaumont Dec. 6, 2001, pet. filed).

bad faith and breach and contract claims into separate lawsuits, then entered judgment in favor of the insured for the breach of contract claim.²¹⁰

The key issue on appeal was whether the insured's incident constituted a "motor vehicle accident." In reaching its decision, the court analyzed two lines of cases: (1) cases where the vehicle is only incidentally involved and provides the "mere situs" for an incident that could have occurred anywhere, and (2) cases where the injury-producing act involved the use of a vehicle as a vehicle. Applying these principles to the facts, the court noted that the inherent nature of the insured's pickup truck is an instrument of conveyance," which necessarily involves both mounting and dismounting.²¹¹ Since the insured was exiting the truck when his foot got caught on a part of the truck itself, the court found that "no intervening instrumentality disrupted the causal chain between the use of the truck as a vehicle and the injury resulting from that use."²¹² The court further held that "viewing the policy as a whole, the term 'motor vehicle accident' does not necessitate any physical impact, provided the facts demonstrate causation between the use of the vehicle and the accidental injury to the covered person." Thus, despite the fact that the truck was stationary, the court held that the insured was still using the truck as a means of transportation at the time of the injury. Accordingly, the court held that "[the insured's] injury was caused by a 'motor vehicle accident' within the meaning of his automobile policy."²¹³

E. WORKERS' COMPENSATION

Insurer's Waiver of Subrogation Rights Does Not Violate Public Policy

In *American Risk Funding Ins. Co. v. Lambert*,²¹⁴ the Corpus Christi Court of Appeals addressed whether a carrier can waive the statutory right of workers' compensation subrogation. The case arose after several employees were injured in a chemical plant explosion on the job. The employees filed suit against the owner and operator of the premises where they were injured and the general contractor that performed work at the plant for their employer. American Risk Funding Insurance Company, the workers' compensation carrier, intervened for reimbursement for medical and indemnity benefits that it had paid to the employees in the event the defendants were held liable. The employees eventually settled with the defendants for \$1.8 million; however, they denied American Risk's subrogation claim on the grounds that American Risk had previously entered into a written contract with their employer waiving subrogation rights. The trial court granted summary judgment in favor of the employees.²¹⁵

210. *Id.*

211. *Id.* at *4.

212. *Id.*

213. *Id.*

214. 59 S.W.3d 254 (Tex. App.—Corpus Christi 2001, pet. denied).

215. *Id.* at 256.

On appeal, American Risk argued that enforcement of the waiver of a workers' compensation carrier's right to subrogation is against public policy, because it would allow the employees to have a double recovery. The court rejected this argument, finding that the "employer purchased the workers' compensation benefits as well as the waiver of subrogation and assuming the waiver was valid, [the employees] did not receive anything more than they were entitled to under the terms of the waiver."²¹⁶ The court also noted that there was no proof that the employees received a double recovery.²¹⁷ Rather, the court found that the parties considered the waiver of subrogation rights in arriving at the settlement amount.²¹⁸

Furthermore, the court cited several cases upholding the right of a workers' compensation carrier to either change, reduce or eliminate its subrogation rights by contract. In addition, the court noted that Texas courts have upheld waiver of subrogation rights in third-party actions that did not involve public policy arguments. Finally, the court noted that "where public policy was urged to prevent a worker from contracting away his workers' compensation rights in favor of his employers' benefit plan, the Texas Supreme Court held that public policy in favor of freedom of contract allows such election . . ."²¹⁹ Thus, the court concluded that if public policy would not prevent a worker from signing away his workers' compensation benefits, which may not be as good as those provided by his employer, "public policy should not prevent a carrier from waiving its rights by contract."²²⁰ Accordingly, the court held that the waiver of subrogation did not violate public policy and was not void.

IV. STATUTE OF LIMITATIONS

A. CONTRACTUAL LIMITATION PROVISIONS

Douskos v. Eden Park: Policy Provision Requiring Insured to Bring Breach of Contract Action "Within Two Years" is Void Under Texas Law; Therefore, Four Year Statute of Limitations Applies

The Texas Civil Practice and Remedies Code prohibits parties from entering into agreements, contracts or stipulations that limit the time in which to bring suit on the agreement, contract or stipulation to periods shorter than two years.²²¹ In *Douskos v. Eden Park Insurance Co.*,²²² a Texas federal court addressed the validity of a policy provision requiring an insured to bring an action within two years after the date on which the

216. *Id.* at 257.

217. *Id.*

218. *Id.* at 257.

219. *Am. Risk Funding*, 59 S.W.3d at 258 (citing *Lawrence v. CDB Serv., Inc.*, 44 S.W.3d 544 (Tex. 2001)).

220. *Id.*

221. TEX. CIV. PRAC. & REM. CODE ANN. § 16.070(a) (Vernon 1997). Any provision that limits the time in which to bring suit for a period shorter than two years is void under Texas law.

222. No. CIV.A. A-01-CV-192 JRN, 2001 WL 699092 (W.D. Tex. June 15, 2001).

loss or damage occurred. In that case, the insured purchased an insurance policy from Eden Park Insurance Company covering property at his auto repair shop. The policy contained the following limitation provision:

No one may bring legal action against us under this Coverage Part unless: 1. There has been full compliance with all the terms of this Coverage Part; and 2. The action is brought within 2 years after the date on which the direct physical loss or damage occurred.²²³

On November 30, 1997, a theft occurred at the repair shop, and the insured submitted a claim to Eden Park. Eden Park closed the insured's case without payment on December 10, 1998. On February 15, 2001, the insured sued Eden Park in the United States District Court for the Western District of Texas alleging breach of contract and bad faith claims. Eden Park argued that the contract claims were barred by the two-year limitation contained in the insurance policy and that the insured's tort claims were also barred by the two year statute of limitations. The insured asserted that the two-year provision contained in the insurance policy was void under Texas law and, therefore, the statute of limitations on the contract claims is four years.²²⁴

The issue before the court was whether the phrase "within 2 years" constituted a period shorter than two years in contravention of the Texas Civil Practice and Remedies Code. If it did, then the four-year statute of limitations for contract claims applied and the insured would be allowed to proceed. If not, then the insured's contract claim was time barred. In construing the phrase, the court noted that courts have construed the phrase "within two years" differently. While some courts have held that the phrase includes two years or more, other courts have held that it means a period shorter than two years. Despite these different constructions, the Court noted that under Texas law, the phrase "within 2 years" is construed to mean a period shorter than two years. In reaching this conclusion, the court relied on *Commercial Casualty Insurance Co. v. Loper*,²²⁵ a case holding that a limitation provision which called for causes of action to be filed "within two years" violated a prior version of Texas Civil Practice & Remedies Code Section 16.070 and was void. Thus, applying Texas law, the court held that the limitation provision in question was void and, therefore, the plaintiff's contract claims were subject to the four-year statute of limitations.²²⁶

223. *Id.* at *2.

224. *Id.* at *1-2. Under Texas law, parties are prohibited from entering into agreements, contracts or stipulation that limits the time in which to bring suit on an agreement, contract or stipulation to periods shorter than two years. TEX. CIV. PRACT. & REM. CODE ANN. § 16.070(a) (Vernon 1997). Any provision that limits the time in which to bring suit for a period shorter than two years is void.

225. 104 S.W.2d 580, 581 (Tex. Civ. App.—Beaumont 1937, writ dismissed).

226. *Douskos*, 2001 WL 699092, at *2.

B. BAD FAITH CLAIMS

1. *Insurer's Closure of Case*

Douskos v. Eden Park: Insured's Bad Faith Claim Accrued When Insured Received Notice That Insurer Had Closed the Case and Effectively Denied the Claim

In *Douskos*, with regard to the tort claims, it was undisputed that the statute of limitations was two years, and the claims began to accrue on the date the claim at issue was denied. The parties, however, disputed when the claim was denied. The insured argued that Eden Park denied the claim on March 19, 2001, when it answered the lawsuit. The insured also alleged that Eden Park's letter closing the file on December 10, 1998, was not a proper denial, therefore, the limitations clock did not start when the letter was sent. The court rejected this argument finding that the evidence established that the insured failed to exercise due diligence in pursuing his insurance claim. Specifically, the court stated that "any activity or inquiry by the [insured] within the three and a half years would have revealed that the defendant had closed the case and effectively denied the claim on December 10, 1998. It was that action that unambiguously demonstrated the defendant's intent not to pay the claim."²²⁷

The court found that "no reasonable finder of fact could find that the insured acted with diligence in seeking judicial recourse for his injury."²²⁸ Specifically, the court concluded that the insured's deadline for filing the bad faith causes of action was December 10, 2000, because the insured suffered legal injury when he received the December 10, 1998, letter notifying him that his insurance claim had been closed. Since the insured failed to timely file the claim, the court held that the insured's bad faith causes of action were time barred and should be dismissed.²²⁹

2. *Accrual of Cause of Action*

Cantrell v. Farmers: Statute of Limitations for Bad Faith Denial Accrues Upon Insurer's Denial of Coverage

In *Cantrell v. Farmers Group, Insurance*,²³⁰ an insured attempted to avoid the rule established in *Murray v. San Jacinto Agency, Inc.*²³¹ that a cause of action for bad faith accrues upon denial. The case arose when Lon Cantrell sustained injuries while performing his job duties. Cantrell received medical treatment and some weekly benefit payments from Mid-Century Insurance Company, his workers' compensation insurance carrier. Cantrell initially received treatment from a physician, who referred him to an orthopedic specialist. The orthopedist recommended that Can-

227. *Id.* at *3.

228. *Id.*

229. *Id.*

230. 2001 WL 842031 (Tex. App.—Austin July 26, 2001, pet. denied) (no publication).

231. 800 S.W.2d 826 (Tex. 1990).

trell not return to work; however, the referring physician advised Cantrell's employer that he could return to work and perform light duty. Cantrell's employer extended him a job offer for light-duty. Cantrell declined the offer and was terminated for rejecting the light-duty job offer. On March 31, 1997, Cantrell's workers' compensation benefits were denied based on his failure to accept the job offer. Cantrell did not file suit against his employer until May 6, 1999, and did not assert claims against Mid-Century until he filed an amended petition on November 22, 1999. Mid-Century moved for summary judgment on the limitations defense, and the court granted summary judgment.²³²

On appeal, the parties did not dispute that Cantrell's bad faith claims were subject to a two-year statute of limitations. Instead, the parties disputed when Cantrell's cause of action accrued. In determining when the cause of action for breach of good faith and fair dealing accrued, the court looked to the Texas Supreme Court's decision in *Murray* holding that "the injury producing event is the denial of coverage—when the insurer unreasonably fails to pay the claim—and thus the cause of action accrues and the statute begins to run at denial."²³³

Cantrell, creatively, but unsuccessfully, argued that *Murray* had been impliedly overruled by *Universe Life Insurance Co. v. Giles*.²³⁴ In *Giles*, the Texas Supreme Court held that "a claimant must prove the insurer failed to attempt to effectuate settlement after its liability became reasonably clear" in order to successfully prosecute a claim for bad faith.²³⁵ Cantrell argued that the wording set forth in *Giles* alters when the action accrues and impliedly overrules *Murray*. Specifically, Cantrell argued that under *Giles*, it is now a question of "what the carrier knew, and when, that causes the action to accrue."²³⁶ Cantrell contended that although Mid-Century arguably had a reasonable basis for denying his claim, the cause of action did not accrue until it became reasonably clear to the carrier that it wrongfully withheld benefits. Rejecting this argument, the court concluded that it did not believe the Texas Supreme Court intended to alter the date of accrual of the action. The court held that the "[d]enial of the claim is still the act of injury and thus the triggering event for when limitations begin to run."²³⁷ Thus, the court held that the claims were barred, because Cantrell did not file his action until more than two years after the denial.

232. *Cantrell*, 2001 WL 842031, at *1.

233. *Id.* (citing *Murray*, 800 S.W.2d at 830)).

234. 950 S.W.2d 48, 51 (Tex. 1997).

235. *Cantrell*, 2001 WL 842031, at *3 (citing *Universe Life Ins. Co. v. Giles*, 950 S.W.2d 48, 51 (Tex. 1997)).

236. *Id.*

237. *Id.* at *3.

V. MISCELLANEOUS

A. RECOVERY OF ATTORNEY'S FEES UNDER 38.006 FOR BREACH OF CONTRACT

Grapevine Excavation v. Maryland Lloyds: Texas Supreme Court Resolves Issue of Whether Section 38.006 Exempts Insurers Subject to Its Terms From Paying Attorneys' Fees

Chapter 38 of the Texas Civil Practice and Remedies Code generally provides that litigants may recover reasonable attorney's fees incurred in a valid claim based upon a written contract.²³⁸ Section 38.006, however, provides an exception to this general rule. Section 38.006 provides that Chapter 38 does not apply to a contract issued by insurers who are subject to the following provisions of the Insurance Code: (1) article 3.62, (2) article 3.62-1, (3) chapter 9, (4) article 21.21, or (5) the Unfair Claim Settlement Practices Act (article 21.21-2).²³⁹ For years the Fifth Circuit and the Texas appellate courts have interpreted section 38.006 differently. The Fifth Circuit has interpreted section 38.006 to exempt insurers who are subject to the provisions listed in section 38.006 from paying attorney's fees in breach of contract claims.²⁴⁰ In contrast, the Texas appellate courts have held that the purpose of section 38.006 is to deny attorney's fees under chapter 38 only when attorney's fees are already available under other specific statutes.²⁴¹

In *Grapevine Excavation, Inc. v. Maryland Lloyds*,²⁴² the Texas Supreme Court finally determined which interpretation should be adopted. In that case, an insured sued its insurer for breach of contract for refusing to defend a lawsuit. A federal district court in Texas concluded that the insurer did not owe a duty to defend.²⁴³ The insured appealed, and the

238. TEX. CIV. PRAC. & REM. CODE § 38.001(8) (Vernon 1997).

239. § 38.006.

240. *Bituminous Cas. Corp. v. Vacuum Tanks, Inc.*, 975 F.2d 1130, 1133 (5th Cir. 1992); see also *Lafarge Corp. v. Hartford Cas. Ins. Co.*, 61 F.3d 389, 402-03 (5th Cir. 1995).

241. *Tex. Prop. & Cas. Ins. Guar. Ass'n v. Southwest Aggregates, Inc.*, 982 S.W.2d 600, 613 (Tex. App.—Austin 1998, no pet.); *Whitehead v. State Farm Mut. Auto. Ins. Co.*, 952 S.W.2d 79, 87-88 (Tex. App.—Texarkana) *rev'd on other grounds*, 988 S.W.2d 744 (Tex. 1999); *Novosad v. Mid-Century Ins. Co.*, 881 S.W.2d 546, 552 (Tex. App.—San Antonio 1994, no writ); *Am. Gen. Fire & Cas. Co. v. McInnis Book Store, Inc.*, 860 S.W.2d 484, 490-91 (Tex. App.—Corpus Christi 1993, no writ); *Chitsey v. Nat'l Lloyd's Ins. Co.*, 698 S.W.2d 766, 772 (Tex. App.—Austin), *aff'd*, 738 S.W.2d 641 (Tex. 1987); *Hochheim Prairie Farm Mut. Ins. Ass'n v. Burnett*, 698 S.W.2d 271, 278 (Tex. App.—Fort Worth 1985, no writ); *Martin v. Travelers Indem. Co.*, 696 S.W.2d 450, 451 (Tex. App.—Dallas 1985, writ ref'd n.r.e.); *State Farm Mut. Auto. Ins. Co. v. Clark*, 694 S.W.2d 572, 574-75 (Tex. App.—Corpus Christi 1985, no writ); *Vanguard Ins. Co. v. McWilliams*, 680 S.W.2d 50, 52 (Tex. App.—Austin 1984) writ ref'd n.r.e.); *Commonwealth Lloyd's Ins. Co. v. Thomas*, 678 S.W.2d 278, 283-84 (Tex. App.—Fort Worth 1984, writ ref'd n.r.e.); *Bellefonte Underwriters Ins. v. Brown*, 663 S.W.2d 562, 575 (Tex. App.—Houston [14th Dist.], *rev'd in part on other grounds*, 704 S.W.2d 742, 745 (Tex. 1986); *Tex. Farmers Ins. Co. v. Hernandez*, 649 S.W.2d 121, 124 (Tex. App.—Amarillo 1983, writ ref'd n.r.e.); *Prudential Co. of Am. v. Burke*, 614 S.W.2d 847, 850 (Tex. Civ. App.—Texarkana 1981, writ ref'd n.r.e.).

242. 35 S.W.3d 1 (Tex. 2000).

243. *Federated Mut. Ins. Co. v. Grapevine Excavation, Inc.*, 18 F. Supp. 2d 636 (N.D. Tex. 1998).

Fifth Circuit Court of Appeals reversed the trial court's judgment, holding that the insurer breached its contract by refusing to defend its insured in the underlying lawsuit. The Fifth Circuit remanded the case to the district court to determine the appropriate remedy,²⁴⁴ but retained jurisdiction for the limited purpose of deciding whether the insured was entitled to recover attorney's fees incurred in pursuing the breach of contract action.²⁴⁵ Recognizing that it has interpreted Section 38.006 differently from Texas appellate courts, the Fifth Circuit certified the question to the Texas Supreme Court.²⁴⁶

After considering both interpretations of the statute, the Texas Supreme Court concluded that it should follow "established and longstanding Texas authority that interprets section 38.006 to allow recovery of attorney's fees in successful breach-of-contract action against an insurer unless attorney's fees are otherwise available."²⁴⁷ The Court cited two important reasons for its decision. First, the Court noted that the "Legislature has not substantially changed Section 38.006 since its enactment" even though the appellate courts have consistently held that section 38.006 allows recovery of attorneys' fees against insurers in breach of contract suits. Thus, the Legislature is presumed to have adopted the established judicial interpretation of Section 38.006. Second, the Court held that *stare decisis* demands this result.²⁴⁸ The Court denied the motion for rehearing in January of 2001.

B. ARTICLE 6.15

Morris County National Bank v. John Deere: Article 6.15 Does Not Impose Duty on Insurer to Notify an Insured's Mortgagee of a Policy's Impending Expiration

Article 6.15 of the Texas Insurance Code provides:

The interest of a mortgagee or trustee under any fire insurance contract hereafter issued covering any property situated in this State shall not be invalidated by any act or neglect of the mortgagor or owner of said described property or the happening of any condition beyond his control, and any stipulation in any contract in conflict herewith shall be null and void.²⁴⁹

The purpose of the article is "to protect mortgagees from mortgagor derelictions with respect to insurance policies on mortgaged properties."²⁵⁰ The statute "immunizes the mortgagee against the legal consequences of any act done by the mortgagor or owner either prior to or

244. *Federated Mut. Ins. Co. v. Grapevine Excavation, Inc.*, 197 F.3d 720 (5th Cir. 1999).

245. *Id.* at 1.

246. *Grapevine Excavation, Inc. v. Maryland Lloyds*, 35 S.W.3d at 2 (Tex. 2000).

247. *Id.* at 5.

248. *Id.*

249. TEX. INS. CODE ANN. art. 6.15.

250. *Morris County Nat'l Bank v. John Deere Ins. Co.*, 254 F.3d 538, 540 (5th Cir. 2001) (citing *Standard Fire Ins. Co. v. United States*, 407 F.2d 1295, 1299 (5th Cir. 1969)).

subsequent to the issuance of the policy in question.”²⁵¹ In order to achieve this effect, Article 6.15 creates a new and independent contract between the mortgagee and the insurer.²⁵²

In *Morris County National Bank v. John Deere Ins. Co.*,²⁵³ the Fifth Circuit addressed whether article 6.15 of the Texas Insurance Code imposes a duty on an insurer to notify its insured’s mortgagee of the policy’s impending expiration when the insurance policy does not require such notice. In this case, the insured borrowed \$50,000 from Morris County to purchase a buncher, which is a piece of heavy equipment used in the timber industry to cut down trees. The buncher was insured under a fire insurance policy that named Morris County as the loss payee. The policy was effective from September 24, 1996 to September 24, 1997, and Morris County had a copy of the policy that stated its term. Although the policy did not require the insurer to give either the insured or Morris County notice of its expiration, on September 19, 1997, the insurer warned the insured that the policy would expire on September 24, 1997 unless renewal premiums were paid. The insurer, however, did not give Morris County the same notice. The insured failed to pay the renewal premium, and the policy expired. The insurer notified the insured, but not Morris County, that the policy had expired. After the policy expired, a fire destroyed the buncher, and Morris County demanded \$50,000 under the policy to cover the loss. The insurer denied Morris County’s demand on the grounds that the policy had expired prior to the loss.

Morris County filed a declaratory judgment action seeking judgment that the insurer owed Morris County, “as a mortgagee, reasonable notice of the termination of coverage under the policy before any such termination would become effective as to its interests.”²⁵⁴ Both parties filed motions for summary judgment. “The district court concluded that article 6.15 [of the Texas Insurance Code] required the insurer to give Morris County notice of the policy’s expiration, and, since no notice was given, Morris County still had an interest in the policy. Accordingly, the district court granted summary judgment in favor of Morris County.”²⁵⁵

The issue on appeal was whether article 6.15 imposed a “duty on an insurer to notify its insured’s mortgagee of the policy’s impending expiration when the insurance policy does not require such notice.”²⁵⁶ In addressing this issue, the court looked to the legislative purpose of Article 6.15. The court explained that “[w]hile article 6.15 grants the mortgagee an independent contract with independent rights, it does not free the mortgagee from the responsibilities and limitations of that independent

251. *Id.* (citing *St. Paul Fire & Marine Ins. Co. v. Crutchfield*, 350 S.W.2d 534, 537 (1961)).

252. *Id.* (citing *St. Paul Fire & Marine Ins. Co. v. Crutchfield*, 350 S.W.2d 534, 591 (Tex. 1961)).

253. 254 F.3d 538 (5th Cir. 2001).

254. *Id.* at 541.

255. *Id.*

256. *Id.*

contract.”²⁵⁷ The court noted that in Texas, an insurer is not required to notify the insured of the policy’s expiration in the absence of contrary policy provisions. The court further explained that “[w]hile Texas law clearly grants a mortgagee a contract independent of the mortgagor’s, it does not grant a contract better than the mortgagor’s.”²⁵⁸ Accordingly, the court found that the insurer did not have a duty under Article 6.15 to notify an insured’s mortgagee of the policy’s impending expiration. Thus, the court held that Morris County lost coverage on September 24, 1997, not because the insured’s contract expired or because of his act or omission, but because Morris County’s own contract expired.²⁵⁹

C. CANCELLATION NOTICES

1. *Premium Finance Company’s Cancellation of Policy*

INAC v. Underwriters: Premium Finance Company May Cancel Policy by Same Means as Insured

In *INAC Corp. v. Underwriters at Lloyd’s*,²⁶⁰ the Houston Court of Appeals addressed whether a premium finance company could cancel a policy by mailing notices to the insurers in care of the agent appointed to receive notices of cancellation from the insured. In this case, an insured entered into a contract with a premium finance company under which the premium finance company agreed to finance approximately \$900,000 in premiums for the insured’s purchase of various insurance policies. The contract required the insured to pay the premium finance company eleven monthly installments. As security for its debt, the insured assigned the premium finance company all unearned premiums, policy dividends, and loss payments under the policies. The insured also authorized the premium finance company to cancel the financed policies.²⁶¹

Pursuant to the agreement, the premium finance company forwarded the total premium amount to Insurance Alliance, as the agent for the underwriters at Lloyd’s (“Underwriters”). “Insurance Alliance then accepted the check and deposited the proceeds into its own account. After first deducting and retaining its commissions, Insurance Alliance forwarded the premium funds to Underwriters.”²⁶² Thereafter, the insured failed to make its June payment, and the premium finance company gave the insured notice of default and notice of its intent to cancel. After the insured failed to cure the default, the premium finance company “attempted to cancel the policies by mailing notice of cancellation to the Underwriters in care of Insurance Alliance.”²⁶³ The premium finance

257. *Id.* at 541.

258. *Morris*, 254 F.3d at 542.

259. *Id.*

260. 56 S.W.3d 242 (Tex. App.—Houston [14th Dist.] 2001, rehearing overruled, pet. denied).

261. *Id.* at 245.

262. *Id.* at 246.

263. *Id.*

company filed suit against Underwriters, their agent, and the surplus lines' agent to recover unearned premiums after canceling the policies.

The main issue in this case was whether the premium finance company complied with the Insurance Code when it sent notice of cancellation to Insurance Alliance. Although Underwriters had authorized Insurance Alliance to receive notices of cancellation from the insured, Underwriters claimed that the insurance policies and article 24.17 of the Insurance Code required the premium finance company to forward notice of cancellation directly to Underwriters rather than to their agent, Insurance Alliance. Thus, Underwriters argued that this was not proper notice under Article 24.17. The trial court granted summary judgment in favor of Underwriters.²⁶⁴

On appeal, the Houston Court of Appeals first addressed whether the premium finance company's notice of cancellation complied with Article 24.17. The court noted that under Article 24.17, the premium finance company was required to send notice of cancellation to (1) the insurer, (2) the insured, and (3) the insurance agent or insurance broker indicated on the finance agreement. Underwriters did not dispute that INAC properly mailed notice of the cancellation to the insured and to the broker. The only challenge Underwriters raised regarding Article 24.17 concerned notice to Underwriters. Thus, the issue was whether the language "mailing to the insurer a notice of cancellation in Article 24.17(d) precluded [the premium finance company] from sending notice of cancellation to the Underwriters in care of Insurance Alliance."²⁶⁵ Although the insured could have canceled the policies by sending a cancellation notice to the Underwriters in care of Insurance Alliance, Underwriters argued that "the policies did not state that cancellation [could] be made in this manner by a premium finance company."²⁶⁶ The court noted that the language of Article 24.17 was unambiguous and that the only reasonable interpretation of it is "that a premium finance company may use the same methods of mailing the notice to the insurer that are available to the insured."²⁶⁷ Thus, the court held that "[a]rticle 24.17 allows premium-finance companies to cancel an insurance policy by mailing notice of cancellation to the insurer in care of the agent appointed by the insurer to receive notices of cancellation from the insured."²⁶⁸ Accordingly, the court held that the trial court erred in granting Underwriters' motion for summary judgment.²⁶⁹

2. Cancellation Notices in Contracts

Insurance Co. of North America v. Aberdeen: Where Subcontractor's Insurer Had Duty to Provide Cancellation Notice Directly to General Con-

264. *Id.* at 246-47.

265. *INCA Corp.*, 56 S.W.3d at 248.

266. *Id.*

267. *Id.* at 248.

268. *Id.*

269. *Id.* at 251.

tractor Under Contract, Failure to Do So Rendered Cancellation Ineffective as to General Contractor

In *Insurance Co. of North America v. Aberdeen Ins. Services, Inc.*,²⁷⁰ the Fifth Circuit recently held that a government subcontractor's insurer had a duty to provide cancellation notice directly to the general contractor. The United States Department of Energy ("DOE") contracted with a general contractor to construct an oil pipeline project. Under the contract, the general contractor was required to maintain comprehensive general liability and third party property damage insurance, naming the United States as an additional insured. The DOE also required that it "receive thirty days advance written notice of any changes in, or cancellation of, such insurance policies."²⁷¹ Finally, the contract provided that the general contractor "was fully responsible for all acts and omissions of its subcontractors" and entitled the DOE to assess liquidated damages in the event the contract was not timely completed.²⁷²

The general contractor subcontracted with another party to provide diving services in connection with the pipeline project. The subcontractor's broker for its comprehensive general liability and property damage insurance policies advised the general contractor that: (1) the required insurance was in effect, (2) the general contractor was an additional insured on the policies, and (3) the general contractor would be provided thirty days notice prior to cancellation of the subcontractor's insurance.²⁷³ Thereafter, the subcontractor failed to make a scheduled premium payment, and its insurance was cancelled effective January 15, 1995.²⁷⁴ The general contractor received no notice of cancellation.

After the subcontractor's insurance was cancelled, the subcontractor damaged the pipeline breaking it into two sections. The subcontractor's broker was notified of the accident and responded by sending a notice of cancellation to the general contractor indicating that the policies had been cancelled effective January 15, 1995 due to subcontractor's failure to pay its premiums. As a result, the subcontractor's insurer denied coverage for the loss. The DOE advised the general contractor that it was responsible for its subcontractor's performance and for the delays caused by the accident under the contract, and the general contractor contacted its surety for financial assistance in repairing the pipeline.²⁷⁵

"Following completion of the project, the DOE and the general contractor's surety entered into a settlement agreement under which the DOE assessed liquidated damages of \$615,000"²⁷⁶ due to the general contractor's failure to timely complete the project. The general contractor

270. 253 F.3d 878 (5th Cir. 2001).

271. *Id.* at 881.

272. *Id.*

273. *Id.*

274. *Id.*

275. *Ins. Co. of N. Am.*, 253 F.3d at 882.

276. *Id.*

and its surety then sued the subcontractor's broker and insurer seeking coverage for liquidated damages in the settlement with the DOE. In the lawsuit, the general contractor alleged that (1) it was an additional insured entitled to coverage under the subcontractor's policies, (2) the policies required that the subcontractor's insurer give the general contractor notice prior to cancellation, and (3) the cancellation was ineffective as to the general contractor because the subcontractor's insurer failed to provide the required notice. The district court entered a judgment that the general contractor and its surety receive no damages.

On appeal, the general contractor and its surety argued that the subcontractor's insurer was required to notify the contractor of cancellation of the subcontractor's coverage and that the failure to do so rendered the cancellation ineffective as to the general contractor. The Fifth Circuit Court of Appeals agreed finding that the general contractor had a duty to provide notice of cancellation to the DOE, and the general contractor's duty to provide notice was transferred to the subcontractor pursuant to the terms of the subcontract. As a result, the court held that the subcontractor's insurer had a duty to provide the general contractor notice prior to cancellation of the subcontractor's insurance. Since the subcontractor's insurer failed to provide the required notice prior to canceling the subcontractor's insurance, the court held that the cancellation was ineffective as to the general contractor's loss.²⁷⁷

Next, the court addressed whether the subcontractor's policies covered the general contractor's loss. The court noted that the subcontractor's coverage applied where the subcontractor became "liable or obligated and/or responsible to pay as damages."²⁷⁸ The court found that the subcontractor was responsible for the damage to the pipeline, and the general contractor was fully responsible for the acts of its subcontractors under its contract with the DOE. Accordingly, the court held that the subcontractor's insurance covered the general contractor's loss. Therefore, the court affirmed the district court's denial of the subcontractor's insurer's motion for judgment as a matter of law.

VI. LEGISLATIVE DEVELOPMENTS

During 2001, several significant changes were made to the Texas Insurance Code. The Texas Legislative Counsel has continued in its endeavor to reclassify and rearrange the statutes in a more logical order, employing a numbering system and format that will accommodate future expansion of the law.²⁷⁹ The Legislative Counsel has eliminated invalid, duplicative, and other ineffective provisions in order to avoid confusion. The 77th Legislature also made several substantive changes to the Insurance Code. Many of the substantive changes were enacted to expand coverage and

277. *Id.* at 885-86.

278. *Id.* at 887.

279. See Texas Legislative Counsel Website, Insurance Code Project, available at <http://www.capitol.state.tx.us/incode/background.html>.

benefits under group health plans. The most significant changes are summarized below.

A. GENERAL REQUIREMENTS FOR CARRIERS

1. *Definition of Unfair Competition and Unfair and Deceptive Acts or Practices*

The Legislature amended Article 21.21, Section 4, relating to the definition of unfair competition and unfair and deceptive acts or practices in the business of insurance. The Legislature expanded the list of exceptions to the definition of discrimination or rebates to include waiving surrender charges under an annuity contract “when the contract holder exchanges the annuity contract for another annuity contract issued by the same insurer, if the waiver and the exchange are fully, fairly, and accurately explained to the contract holder in a manner that is not deceptive or misleading.”²⁸⁰

2. *Refund of Unearned Premium Required*

The Legislature added Article 21.29, which provides that if an insurer issues a policy that requires maintenance of an “unearned premium reserve for the portion of the policy premium applicable to the unexpired or unused part of the policy period for which the premium has been paid and the policy is canceled or terminated by the insured or the insurer before the end of the policy term with a remaining unearned premium reserve on the policy, the insurer must promptly refund to the policyholder the appropriate portion of the unearned premium.”²⁸¹

3. *New Agent Licensing Laws*

The 77th Legislature passed three bills affecting licensed insurance agents and agencies in Texas: Senate Bills 314, 414, and 466.²⁸² The most comprehensive bill was Senate Bill 414, which took effect of September 1, 2001.²⁸³ Senate Bill 414 “includes the essential components of the Uniform Producer Licensing Model Act proposed by the National Association of Insurance Commissions, making Texas compliant with the reciprocity requirements found in the federal Gramm, Leach, Bliley Act of 1999.”²⁸⁴

Senate Bill 414 allows “non-resident corporate or partnership agencies to obtain a license and solicit business directly within Texas.”²⁸⁵ This Bill

280. See art. 21.21, section 4, as amended by Acts 2001, 77th Leg., ch. 290, Section 1, eff. Sept 1, 2001. See also Texas Department of Insurance Website, available at <http://www.tdi.state.tx.us/company/lhimplemb003601.html>.

281. Art. 21.29, as added by Acts 2001, 77th Leg., ch. 844, Section 1, eff. Sept. 1, 2001.

282. See Texas Department of Insurance website, available at <http://www.tdi.state.tx.us/commish/b-0034-1.html>.

283. *Id.* See also Senate Bill 414, as enacted by Acts 2001, 77th Leg., eff. Sept. 2, 2001.

284. *Id.*

285. *Id.*

also consolidates “agent licenses into fewer license types.”²⁸⁶ For example, with regard to General Lines Property and Casualty licenses, the following prior licenses have been consolidated into a new single license: (1) 05-10 Local Recording Agent-Temporary, (2) 06-00 Solicitor for Local Recording Agent, and (3) 10-00 Non-Resident Property and Casualty Agent.²⁸⁷

The Legislature also eliminated “the requirement that all officers, directors, and shareholders of a corporate agency or partners of a partnership reside in Texas and hold an agent’s license.”²⁸⁸

Senate Bill 414 further provides that the “referral by an unlicensed person to an insurance agent is not the act of an agent if the unlicensed person does not discuss specific insurance policy terms or conditions with the customer or potential customer.”²⁸⁹ In addition, “a referral fee may be paid to such an unlicensed person if the payment is not based upon the purchase of insurance by the customer.”²⁹⁰

Finally, Senate Bill 414 provides that a “General Lines Life, Accident, Health and HMO agent or a General Lines Property and Casualty agent may appoint a licensed agent as a subagent to act under the sponsoring agent’s license.”²⁹¹ The Bill provides that the subagent: “(1) may represent the insurance carriers to which the sponsoring agent is appointed and is not required to be separately appointed by the insurance carriers; (2) must be licensed to write each type of insurance he is employed to write, but is not required to hold each type of license issued to the sponsoring agent or agency; (3) may be individually appointed by insurance carriers as well as being appointed as a subagent; and (4) may be appointed as a subagent of multiple sponsoring agents and agencies.”²⁹²

B. LIFE, HEALTH, AND ACCIDENT POLICIES

1. Insurer Antifraud Programs

The Legislature added Subchapter K (Insurer Antifraud Programs) to Title 1, Chapter 3 of the Insurance Code. This subchapter requires that forms provided by health insurers to persons to make a claim or to give notice of a claim must include a “statement substantially similar to the following: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.”²⁹³ This requirement does not apply

286. *Id.* Senate Bill 414 reduces the number of agent licenses from 44 to 23.

287. See Texas Department of Insurance website, available at <http://www.tdi.state.tx.us/commish/b-0034-1.html>.

288. *Id.*

289. *Id.* (internal quotations omitted).

290. *Id.*

291. Tex. Dep’t of Ins. website, available at <http://www.tdi.state.tx.us/commish/b-0034-1.html>.

292. *Id.*

293. Art. 3.97-2, as added by Acts 2001, 77th Leg., ch. 1033, Section 3, eff. Sept. 1, 2001.

against a policy issued by a reinsurer.²⁹⁴

Subchapter K also requires health insurers who collect direct written premiums to adopt an antifraud plan that includes a description of the insurer's procedures for detecting, investigating, and reporting possible fraudulent insurance acts.²⁹⁵

2. *Disclosure of Contact Person to Insured or Enrollee of Health Benefit Plan*

The Legislature added article 21.24-3, which requires an issuer of a health benefit plan to provide the following information to the insured or enrollee upon request: (1) the name or employee identifier, (2) mailing address, business city and state location, and (3) job title of the employee of the issuer of the health benefit plan who is available to respond to communications and questions from the insured or enrollee relating to coverage and benefits provided by the health benefit plan.²⁹⁶

3. *Disclosure of Claims Cost Information to Employer*

The Legislature added article 21.49-19, which requires issuers of group health benefit plans to provide claims "cost information for employees covered by the plan during the preceding calendar year" upon request of an employer sponsoring a group health benefit plan.²⁹⁷ "The information must be reported separately for each month during which the plan was in effect."²⁹⁸ This statute also provides that the "[i]nformation obtained by the employer is confidential and may only be used by the employer for purposes relating to obtaining and maintaining group health benefit plan coverage for the employer's employees."²⁹⁹

4. *Availability of Certain Reimbursement Guidelines Used by Managed Care Entity*

Article 21.60 was added and it made reimbursement guidelines used by managed care entities available to certain health providers. This article requires that upon written request, "a managed care entity shall provide [the out-of-network health care] provider with a written description of the factors considered by the managed care entity in determining the amount of reimbursement that the out-of-network provider may receive for goods or services provided to a person enrolled in or insured under the entity's managed care plan."³⁰⁰ This article does not require a managed care entity to disclose proprietary information, which is prohibited

294. *Id.*

295. Art. 3.97-3, as added by Acts 2001, 77th Leg., ch. 1033, Section 3, eff. Sept. 1, 2001.

296. Art. 21.24-3, section 2, added by Acts 2001, 77th Leg., ch. 1266, Section 1, eff. Sept. 1, 2001.

297. Art. 21.49-19, section 3, added by Acts 2001, 77th Leg., ch. 1450, Section 1, eff. Sept. 1, 2001.

298. *Id.*

299. *Id.*

300. Art. 21.60, as added by Acts 2001, 77th Leg., ch. 672, Section 1, eff. Sept. 1, 2001.

from disclosure by a contract between the managed care entity and a vendor who supplies payment or statistical data to the managed care entity.

5. *Expanded Coverage for Dependents Under Group Health Plans*

The Legislature expanded coverage for dependents under several provisions of the Insurance Code. First, “a dependent grandchild of an employee or member who is less than 21 years old and living with and in the household of the employee or member,” may now be included within the coverage of a group health plan, regardless of whether the employee or member treats the grandchild as a dependent for federal income tax purposes.³⁰¹

The Legislature also enacted chapter 1027 amending section 3B of article 3.51-6, effective September 1, 2001. Pursuant to this provision, “a health insurance policy that provides coverage for a child of the policyholder must upon payment of a premium provide coverage for any unmarried child of the policyholder’s child if the child is younger than 25 years of age and is a dependent of the policyholder for federal income tax purposes at the time application for coverage of the child is made.”³⁰² Coverage for dependent grandchildren under this provision may not be terminated solely because the covered child is no longer a dependent of the policyholder for federal income tax purposes.³⁰³

The Legislature also amended Article 3.70-2 to provide that an insurer may no longer require a stepchild to reside with the member or person insured.³⁰⁴

Finally, with respect to pool coverage, the Legislature expanded the definition of a “dependent” to include the following: (1) “a child who is a student under the age of twenty-three years and who is financially dependent upon the parent,” (2) “a child for whom a person may be obligated to pay child support,” or (3) “a child of any age who is disabled and dependent upon the parent.”³⁰⁵

301. Art. 3.51-6 section 1, subsection (b) as amended by Acts 2001, 77th Leg., ch. 396, Section 1, eff. Sept. 1, 2001.

302. Art. 3.51-6 section 3B, subsection (b), as amended by Acts 2001, 77th Leg., ch. 1027, Section 2, eff. Sept. 1, 2001. The Legislature, however, also enacted Chapter 396, Section 2, which is also effective September 1, 2001. Chapter 396 provides that for purposes of the subchapter, a child of the policyholder’s child is a dependent of the policyholder regardless of whether the policyholder treats the child as a dependent for federal income tax purposes.

303. *Id.*

304. Art. 3.70-2, section 2, as amended by Acts 2001, 77th Leg., ch. 1027, Section 2, eff. Sept 1., 2001.

305. Art. 3.77, section 10, subsection (e), as amended by Acts 2001, 77th Leg., ch. 1084, Section 2, eff. Sept. 1, 2001. The Legislature also enacted Chapter 1027, which is also effective September 1, 2001. That chapter, however, provides that a dependent includes a child who is a student under 25 years of age and who is financially dependent upon the parent, a child for whom a person may be obligated to pay child support, or a child of any age who is disabled and dependent upon the parent.

6. *Women's Equal Health Care Act*

The Legislature passed an Act called the Women's Equal Health Care Act. The purpose of this Act is to require equal reimbursement and compensation to women under health care plans. The Act provides that "when reimbursing a physician or provider for reproductive health and oncology services provided to women, a health benefit plan "must pay an amount not less than the annual average compensation per hour or unit as would be paid in the service area . . . for the same medical, surgical, hospital, pharmaceutical, nursing, or other similar resources, as applicable, that would be used in providing health services exclusively to men or to the general population."³⁰⁶ A health benefit plan that is found to be in violation of this Act is subject to: (1) "the sanctions authorized by chapter 82 of this code;" (2) "cease and desist procedures authorized by Chapter 83, including restitution which may include complainant's reasonable attorney fees and the greater of complete or economic damages" and (3) "administrative penalties not to exceed \$25,000 for violations of the Act."³⁰⁷ The Act also provides for judicial review, which may result in a "civil penalty of \$25,000 if a trier of fact finds that the defendant knowingly violated the provisions of this article."³⁰⁸

7. *Coverage for Prescription Contraceptive Drug and Devices and Related Services*

The Legislature enacted Article 21.52L, which expands coverage under group health plans to cover prescription contraceptive drugs and devices and related services. This Act became effective September 1, 2001 and applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2002. The Act prohibits "[a] health benefit plan that provides benefits for prescription drugs or devices may not exclude or limit benefits to enrollees for: (1) a prescription contraceptive drug or device approved by the United States Food and Drug Administration, or (2) an outpatient contraceptive service."³⁰⁹ The insurer may, however, provide "a limitation that applies to all prescription drugs or devices or all services for which benefits are provided under a health benefit plan."³¹⁰ Furthermore, this Article does not provide coverage for any drugs or devices that terminate a pregnancy.³¹¹

Article 21.52L also prohibits insurers from engaging in prohibited conduct, which would impact the effectiveness of this Article. Specifically,

306. Art. 21.53N, section 3, as added by Acts 2001, 77th Leg., ch. 1214, Section 3, eff. Sept. 1, 2001.

307. Art. 21.53N, section 4, as added by Acts 2001, 77th Leg., ch. 1214, Section 3, eff. Sept. 1, 2001.

308. Art. 21.53N, section 5, as added by Acts 2001, 77th Leg., ch. 1214, Section 3, eff. Sept. 1, 2001.

309. Art. 21.52L, section 3, as added by Acts 2001, 77th Leg., ch. 1106, Section 1, eff. Sept. 1, 2001.

310. *Id.*

311. *Id.*

insurers are prohibited from imposing “any deductible, copayment, coinsurance, or other cost-sharing provision applicable to benefits for prescription contraceptive drugs or devices, unless the amount of the required cost-sharing does not exceed the amount of the required cost-sharing applicable to benefits for other prescription drugs or devices under the plan.”³¹² In addition, insurers are prohibited from imposing any “waiting period applicable benefits for to prescription contraceptive drugs or devices, unless the waiting period is not longer than any waiting period applicable to benefits for other prescription drugs or devices, under the plan.”³¹³

Furthermore, insurers cannot “deny applicants for enrollment or deny an enrollee eligibility or continued eligibility under the plan, or deny renewal of the plan, to an enrollee solely because of the applicant’s or enrollee’s use or potential use of a prescription contraceptive drug or device or an outpatient contraceptive service.”³¹⁴ “Insurers are also prohibited from providing monetary incentive to an applicant for enrollment or enrollee to induce . . . [them] to accept coverage that does not satisfy the requirements” of Article 21.52L.³¹⁵ Finally, insurers cannot “reduce or limit a payment to a health care professional, or otherwise penalize the professional, because the professional prescribes a contraceptive drug or device or provides an outpatient contraceptive service.”³¹⁶

This Article, however, “does not require a health benefit plan that is issued by an entity associated with a religious organization or any physician or health care provider providing medical or health care services under the health benefit plan to offer, recommend, offer advice concerning, pay for, provide, assist in, perform, arrange, or participate in providing or performing a medical or health care service that violates the religious convictions of the organization, except if the prescription contraceptive coverage is necessary to preserve the life or health of the insured individual.”³¹⁷

8. Coverage for Neurological Injuries

The Legislature enacted Article 21.53Q, which prohibits insurers under health benefit plans from excluding “coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological,

312. Art. 21.52L, section 4, as added by Acts 2001, 77th Leg., ch. 1106, Section 1, eff. Sept. 1, 2001.

313. Art. 21.52L, section 5, as added by Acts 2001, 77th Leg., ch. 1106, Section 1, eff. Sept. 1, 2001.

314. Art. 21.52L, section 6, subsection (1), as added by Acts 2001, 77th Leg., ch. 1106, Section 1, eff. Sept. 1, 2001.

315. See Art. 21.52L, section 6, subsection (2), as added by Acts 2001, 77th Leg., ch. 1106, Section 1, eff. Sept. 1, 2001.

316. Art. 21.52L, section 6, subsection (3), as added by Acts 2001, 77th Leg., ch. 1106, Section 1, eff. Sept. 1, 2001.

317. See Art. 21.52L, section 7, as added by Acts 2001, 77th Leg., ch. 1106, Section 1, eff. Sept. 1, 2001.

and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.”³¹⁸ Coverage under this Article, however, “may be subject to deductibles, copayments, coinsurance, or annual or maximum payment limits that are consistent with deductibles, copayments, coinsurance, and annual or maximum payment limits applicable to other similar coverage under a health plan.”³¹⁹

9. *Periodic Health Evaluations Required for Health Maintenance Organizations*

Article 20A.09B was amended to require periodic health evaluations for each adult enrollee of a Health Maintenance Organization. The Article now requires a “health risk assessment at least once every three years and an annual well woman examination” for each female enrollee.³²⁰

10. *Coverage for Tests for Colorectal Cancer*

Finally, the Legislature added Article 21.53S, which requires health benefit plans that provide “benefits for screening medical procedures must provide coverage for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer.”³²¹ Article 21.53S provides a list of the minimum benefits that must be provided for such screening.³²² “Each health benefit plan shall provide written notice to each person enrolled in the plan regarding coverage by the article.”³²³

C. FIRE INSURANCE

The Legislature added a provision prohibiting insurers from using endorsements “that reduce[s] the amount of coverage . . . that would otherwise be provided under [a fire insurance] policy unless the insurer provides the policyholder with a written explanation of the change made by the endorsement before the effective date of the change.”³²⁴

318. See Art. 21.53Q, section 2, as added by Acts 2001, 77th Leg., ch. 859, Section 1, eff. Sept. 1, 2001.

319. *Id.*

320. See Art. 20A.09B, as added by Acts 2001, 77th Leg., ch. 1369, Section 1, eff. Sept. 1, 2001.

321. Art. 21.53S, section 3, as added by Acts 2001, 77th Leg., ch. 956, Section 1, eff. Sept. 1, 2001.

322. Art. 21.53S, section 3, as added by Acts 2001, 77th Leg., ch. 956, Section 1, eff. Sept. 1, 2001.

323. Art. 21.53S, section 4, as added by Acts 2001, 77th Leg., ch. 956, Section 1, eff. Sept. 1, 2001.

324. Art. 5.36, as added by Acts 2001, 77th Leg., ch. 415, Section 1, eff. Sept. 1, 2001.

D. WORKERS' COMPENSATION AND LONGSHOREMEN'S AND HARBOR
WORKERS' COMPENSATION INSURANCE

"Effective September 1, 2001, the Texas Workers' Compensation Insurance Fund will operate as . . . a domestic mutual insurance company in accordance with Chapter 15 of this [Insurance] code, and shall be called the Texas Mutual Insurance Company."³²⁵ The company is subject to Chapter 15 of the Insurance Code, except for Article 15.22 of the Insurance Code.

E. ENFORCEMENT OF INSURANCE POLICIES AFFECTING CERTAIN
HOLOCAUST VICTIMS

The Legislature added Article 21.74, which suspends the statute of limitations period for enforcement of certain policies affecting Holocaust victims. This article permits that a "Holocaust victim, or the heir, assignee, beneficiary, or successor of a Holocaust victim, who resides in [Texas] and has a claim arising out of an insurance policy purchased or in effect in Europe before 1946 that was delivered, issued for delivery, or renewed by an insurer may bring an action against an insurer to recover on that claim in a court of competent jurisdiction in [Texas]."³²⁶ This section further provides that such an action "may not be dismissed for failure to comply with any applicable limitations period if the action is brought before December 31, 2012."³²⁷

325. Art. 5.76-3, Section 2, as amended by Acts 2001, 77th Leg., ch. 1195, Section 1.01, eff. Sept. 1, 2001.

326. Art. 21.74, as added by Acts 2001, 77th Leg., ch. 391, Section 1, eff. May 28, 2001.

327. Art. 21.74, as added by Acts 2001, 77th Leg., ch. 391, Section 1, eff. May 28, 2001.

